



**DEPARTMENT OF
MANAGED HEALTH CARE**

EXAMINER'S GUIDE



OFFICE OF HEALTH PLAN OVERSIGHT

DIVISION OF FINANCIAL OVERSIGHT

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DRAFT**

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INTRODUCTION

This Examiner's Guide sets out guidance for a Department of Managed Health Care ("DMHC" or "Department") examiner to conduct an examination of a health care service plan. The primary goals of the examination is to assess the overall fiscal soundness and financial viability of each plan, as well as, verify the plan's compliance with the Knox-Keene Act and related Rules.

This Examiner's Guide contains procedures performed in a full scope examination. However, the DMHC has instituted a risk-based approach that requires examiners to exercise their professional judgment to assess the risk inherent in a given plan's operation and determine the scope of the examination taking into consideration the many variables and uniqueness presented in each individual plan. After examiners determine existing or potential risk is present, they may perform some or all of the procedures pertaining to a certain risk area as described in this Examiner's Guide.

This Examiner's Guide is prepared specifically for DMHC examiners. It has been posted to the DMHC website to offer information that plans may find useful when they have questions about the examination process.

This Examiner's Guide is a work in process document and as such is designated as a "Draft".

This guide was updated under the direction of Mark Wright with the assistance from the following DMHC staff: Joan Larsen, Janet Nozaki, Richard Martin, Shelly Tang, Kristin Forsberg, Agnes Dougherty, Kim Malme, Tom Roedl, Ned Gennoui, Martha Villegas and Barbara Yaklin. The Guide is updated for amendments to the Act and Regulations as they become effective.

This Examiner's Guide is a reference source for the DMHC examiner and should not be relied upon for any other purpose.

MISSION STATEMENT

The mission of the DMHC's Division of Financial Oversight is to protect Californians who receive services from licensed health care service plans and their provider networks by ensuring that they are fiscally viable and comply with the financial provisions of the Knox-Keene Act and related rules. This mission shall be accomplished through the performance of onsite regulatory examinations, analysis of regulatory filings and requiring necessary corrective actions in coordination with other disciplines in the Department.

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SECTION I. PRE-FIELDWORK - ROUTINE REGULATORY EXAMINATION

RISK-BASED APPROACH

The purpose of the Department's financial examination of a health care service plan is to comply with Section 1382 (a) which states, "The director shall conduct an examination of the fiscal and administrative affairs of any health care service plan, and each person with whom the plan has made arrangements for administrative, management, or financial services, as often as deemed necessary to protect the interest of subscribers or enrollees, but not less frequently than once every five years." This examination determines whether the plan's books and records substantiate the financial statements submitted to the Department.

The Department also conducts non-routine and orientation examinations. Non-routine examinations are conducted, pursuant to Rule 1300.82.1, on an as needed basis and the procedures are focused on specific areas of concern. An orientation examination is performed on a new plan after it has been licensed for a year. An Orientation examination includes: (1) a limited review of the plan's books and records; (2) procedures to determine the plan's compliance with the Act and Rules; and, (3) procedures to determine that the plan is operating in a manner consistent with the representations made in its license application. Orientation examinations are also an opportunity for the Department to provide technical assistance to new plans and answer any question they may have.

The Department determines its examination schedule on a continuous basis, subject to the mandated timeframes, with the objective to apply examination resources to the health care service plans that are financially troubled or in violation of laws relating to financial requirements. These examinations follow best business practices (i.e., Generally Accepted Auditing Standards, Generally Accepted Accounting Principles ("GAAP") and AICPA Audit and Accounting Guide for Health Care Organizations) to ensure they are adequately planned and controlled. The Department takes a risk-based approach in determining the appropriate examination scope, be it full or limited in scope, that results in examination fieldwork emphasizing the risk areas in a plan's financial viability and impact on tangible net equity compliance.

The Department conducts annual examinations of the largest full service plans for specific risk areas. In addition, those plans that have financial problems or are in violation of laws relating to financial requirements are examined on a more frequent basis. Currently, the Department's routine examinations are on a three-year cycle. The Department strives to conduct these examinations efficiently and effectively.

The Department recognizes the need to have a well-developed plan that communicates the planned scope, clearly defines the procedures, level of effort and risk areas to the examination team. The Department's planning process utilizes requested data received from and through inquiries of the health care service plan's personnel, as well as documentation filed with the Department.

The Examiner-in-Charge prepares a Risk Assessment to identify the high-risk financial statement accounts and related business processes. This risk-based approach takes into consideration the following:

- Management and operational processes of the health care service plan.
- Current and past regulatory issues with the Department.
- Analytical Analysis of financial statements filed with the Department.
- Independent audit results.
- Business and Economic environment issues.
- Management disclosure of new premium structures, new benefit packages, new service areas, new or revised provider compensation packages that may impact financial performance.

The Examiner-in-Charge, with oversight by the Supervising Examiner, uses the Risk Assessment to prepare a Planning Memorandum for internal Department purposes that sets forth the areas requiring examination with an assessment for the potential misstatement of financial statement accounts and noncompliance with statutory requirements. The Examiner-in-Charge prepares an examination program that details the financial and statutory compliance procedures to be performed by the staff examiners, and prepares a time budget of staff hours.

EXAMINATION PROTOCOL

In the regulatory financial examination process there is a line of authority, with responsibilities attached to each position.

EXAMINER IN CHARGE (EIC)

The EIC is responsible for the day-to-day performance and completion of the examination, as follows:

1. Planning the examination:
 - a. Perform risk assessment.
 - b. Prepare planning memorandum and time budget.
 - c. Determine examination procedures.
 - d. Update written plans periodically to reflect progress.
 - e. Communicate planned scope, level of effort and risk areas to examiner staff once approved by Supervising/Oversight Examiner prior to the commencing of fieldwork.
 - f. Determine timing of pre-field work survey (if needed), fieldwork and exit conference with Supervising Examiner.
 - g. Preparation and mailing of a notification letter to the plan prior to the survey and/or prior to the fieldwork, as necessary.
 - h. Coordinate the arrival time of staff examiners on the first day of the fieldwork.
 - i. Determine travel requirements and obtain driving directions to the plan and provide this information to staff examiners.
 - j. Ensure that sufficient computers, printers and other necessary supplies are available.
2. Supervision of staff examiners:
 - a. Allocation of work assignments, giving consideration to the experience and training needs of staff.
 - b. Direct the examiner's approach to the review of each account, taking into consideration the examiner's experience.

- c. Review each examiner's progress with work assignments and revise, if necessary.
- d. Be aware of examiner findings for each work assignment.
- e. Review all work papers (i.e., financial, statutory compliance and other, such as questionnaires, representation letters, and time sheets) prepared by examiners for completeness and quality, as follows:
 - Determine accuracy and proper support of examination balance, exceptions, adjustments or reclassifications (including any support to/from another work paper).
 - Determine procedures performed are in compliance with Examination Program and Examiner Guide.
 - Ensure work papers are properly cross-referenced.
 - Ensure exceptions are clearly "red-checked".
 - Ensure work papers are initialed and dated by examiner.
 - Ensure work paper identifies each "Difference" or "Exception" and is supported by a narrative that may be lifted directly to the Preliminary Report.
 - Ensure work paper adequately explains an exception being "Passed" on.
 - Prepare notes and/or discuss any necessary changes or corrections required with the examiner that prepared the work paper.
 - Ensure changes or corrections to work papers are made while in the field.
 - Perform final review to ensure changes and corrections were made as requested.
 - Discretion may be used as to whether minor corrections are forwarded to the examiner who prepared the work paper, or they are made by the EIC. For example, missing cross-references.
- f. Review the Examination Program.
 - Verify procedure was performed.
 - Verify examiner initialed, dated and provided work paper reference for each procedure performed.
 - Verify procedure not performed is identified with a brief explanation of reason.
- g. Ensure that all work papers are completed in the field, and within the budgeted timeframe.
- h. Monitor progress of examination with time budget and planning memo.
- i. Provide on-the-job training of examiners.
- j. Ensure professional conduct of examiners.

3. Establish a filing system at the plan location whereby all staff examiners can locate frequently used documents.
4. Maintain security of Department and plan records and information.
5. Act as chief liaison with plan management.
 - a. Communicate deficiencies during the fieldwork.
 - b. Document these discussions.
 - c. Communicate any additional deficiencies noted during the "wrap-up" process, prior to the exit-conference.
6. Act as liaison with Supervising/Oversight Examiner.
 - a. Provide work papers that are complete and reviewed by EIC for oversight review at field site visits.
 - b. Communicate major exceptions or other plan or personnel issues that impact the efficiency or effectiveness of the examination.
 - c. Discuss and resolve any major differences that EIC was unable to resolve with staff examiners.
7. Complete the "Plan Overview" work paper or assign to staff examiner with review by EIC.
8. Preparation of Preliminary Examination Report
 - a. Perform the examination wrap-up in the field. This function may be assigned to a staff examiner. Then the EIC will act as a resource to the staff examiner.
 - b. Review of completed wrap-up, if performed by a staff examiner. Review the completed work papers and the assembly of work papers. The depth of the review will correlate to the experience of the staff examiner. Minor corrections may be made by the EIC, but staff examiner makes major corrections.
 - c. Prepare "draft" preliminary report in the field.
9. Completed/Assembled Work papers and "draft" Preliminary Report.
 - a. Forward to the Supervising/Oversight Examiner for review.

- b. Respond to questions and perform corrections as required following the Oversight's review.
 - c. Complete Time Budget and Time Reports:
 - Obtain from each staff member assigned to the examination a completed Time Report, which provides dates and hours worked by type of assignment (no expenses).
 - File the Time Report for each staff member as part of the work papers.
 - Update the Time Budget with actual hours through issuance of the Preliminary Report and include an estimate of hours through issuance of the Final Report. File original in the work papers and submit a copy to Oversight Examiner with the Preliminary Report.
 - d. Act as resource to the Oversight Examiner during the review and finalization process of the Preliminary Report. Assist as requested.
10. Schedule and conduct the Exit Conference between plan management and Department representatives (Oversight Examiner and staff examiners, as necessary).
11. Review the plan's response to the Preliminary Report and prepare or review the "draft" Final Report, as requested by the Oversight Examiner.

STAFF EXAMINER

The staff examiner is responsible for the performance and completion of their work paper assignments, as follows:

1. Inform the EIC of areas of the examination where you need training and/ or additional experience.
2. Communicate to EIC any changes to the examiner's fieldwork schedule, which are to be approved by the examiner's direct supervisor.
3. Ensure computer, appropriate materials and sufficient supplies are brought to the plan location.
4. Direct all questions to the EIC, as appropriate. Questions relating to an account under review by the examiner may be directly addressed to plan personnel, considering the level of examiner experience.
5. Disagreement with EIC on procedures or conclusions:

- a. State point of view to the EIC and have active discussion, with an understanding that the EIC has the final responsibility for the resulting decision.
 - b. Document "difference of opinion" on the work paper, if unable to resolve difference of opinion.
6. Preparation of work papers:
- a. Complete in the field.
 - b. Perform procedures in compliance with Examination Program and Examiner Guide.
 - c. Review for accuracy and proper support of examination balance, exceptions, adjustments or reclassifications (including any support to/from another work paper).
 - d. Discuss with EIC, and other examiner, an adjusting journal entry or reclassification entry that impacts another account, so that the examiner working on the effected work paper does not duplicate any work.
 - e. Cross-reference work papers, as appropriate.
 - f. Ensure exceptions are clearly stated and "red-checked".
 - g. Assign work paper number, initial and date each work paper.
 - h. Prepare a narrative that may be lifted directly to the Preliminary Report that supports each work paper that identifies a "Difference" or "Exception".
 - i. Provide an adequate explanation for an exception being "Passed".
 - j. Complete any necessary changes or corrections brought to your attention by EIC or Supervising/Oversight Examiner in a timely manner.
 - k. Ensure changes or corrections to work papers are made while in the field.
 - l. Perform final review to ensure changes and corrections were made as requested before final submission to EIC for review.
7. Track time by work assignment through out the examination and monitor closely with time budget. Properly complete a Time Report for the dates and hours worked on each assignment and provide it to the EIC upon completion of the examination for placement in the work papers.

8. Ensure that all assigned work papers are completed in the field, are prepared with high quality and within the budgeted time frame.

SUPERVISING/OVERSIGHT EXAMINER

The Oversight Examiner is responsible for the overall performance and completion of the examination, as follows:

1. Planning the examination.
 - a. Discuss the examination timeframe, staffing, and proposed budget with the EIC.
 - b. Gain an understanding of the plan's operations through review of Department resources.
 - c. Discuss with the EIC and select G/L accounts to be reviewed during the fieldwork. Explain the reasons for the selection, if different from EIC.
 - d. Review and approve planning memo and time budget prepared by EIC.
2. Act as a resource for the EIC throughout the examination.
 - a. Attend pre-fieldwork survey, if performed.
 - b. Visit the field at least once a week or more frequently as determined by the complexity of the examination.
 - c. Attend meetings or walk-through of areas with plan personnel that are significant to the examination to ensure understanding of plan operations.
 - d. Coordinate with Chief Examiner and other Divisions within the Department, as necessary, to obtain direction on any issues identified that are not fully financial or require enforcement action.
3. Supervision of examination.
 - a. Review progress with work assignments, planning memo and time budget. Discuss any significant concerns that may require deviation from established work assignments, planning memo or time budget with EIC.
 - b. Review completed work papers that are "signed off" by the EIC, during weekly field visits. Determine procedures performed in compliance with Examination Program and Examiner Guide.
 - c. Oversight initials and dates individual work papers as review is completed.

- d. Any corrections or additional work that results from the Oversight's review should be addressed to the EIC. If the staff examiner is a trainee it may be appropriate to address the comments to both the EIC and the staff examiner concurrently.
 - e. Ensure that adequate on-the-job training is provided to any examiner for which the need was identified at the start of the examination.
 - f. Ensure professional conduct of examiners.
- 4. Act as additional liaison with plan management.
 - a. Communicate significant deficiencies during the fieldwork, along with EIC.
 - b. Discuss any personnel issues that impact the efficiency or effectiveness of the examination.
 - c. Listen to any complaints, determine and take appropriate action.
 - d. Act as a resource to plan management.
- 5. Act as liaison with Chief Examiner to keep him/her informed of any significant findings and status of examination.
- 6. Act as liaison with Chief Licensing Counsel to determine whether changes to administrative agreements, contracts or in the plan's operations need to be filed as an amendment or material modification.
- 7. Review Completed/Assembled Work Papers and Preliminary Report.
 - a. Oversight and EIC establish a tentative end-of-fieldwork date for the completion and assembly of work papers through drafting of the Preliminary Report, as well as tentative date for Exit Conference.
 - b. Oversight establishes time to perform final review of assembled work papers and "draft" Preliminary Report, keeping in mind that the EIC may need time to make any additional corrections and changes, and the Oversight needs time to review those changes prior to the Exit Conference.
 - c. Inquire of the Monitoring Examiner and Supervisor of Monitoring Examiner as to whether there are any current issues before the Department that need to be considered prior to issuance of the Preliminary Report.
 - d. Oversight coordinates review of the "draft" Preliminary Report by the Chief Examiner, prior to the Exit Conference, when significant findings are addressed.

- e. Upon completion of review, the Oversight signs and dates the first work paper in Volume 1 of the work papers. This indicates that the Oversight Examiner is satisfied that the work papers represent the objectives of the examination and support the examination findings.
 - f. Determine that Time Budget is updated for actual time and variances with budget are adequately justified.
 - g. Final hours for examination are sent to designated staff position in Sacramento Office responsible for updating examination activity report.
8. Exit Conferences and Issuance of Preliminary Report.
- a. Accompany the EIC to the Exit Conference, to act as a resource and to provide support.
 - b. Following the Exit Conference the EIC or the Oversight Examiner makes any necessary changes to the “draft” Preliminary Report.
 - c. Perform final review of the Preliminary Report, sign it and mail it.
 - d. Distribute copies of Preliminary Report to appropriate parties.
 - e. The Oversight Examiner or the EIC will retain the work papers until the Final Report is issued and responded to by the plan. Then the work papers are filed on the work paper shelves in alpha order.
9. Preparation and Issuance of Final Report.
- a. Review the plan's response and “draft” the Final Report, or assign this responsibility to the EIC with Oversight review.
 - b. Discuss unresolved significant issues from the Preliminary Report that are to be addressed in the Final Report with the Chief Examiner, to determine if a referral to the Office of Enforcement is warranted.
 - c. Prepare referral to the Office of Enforcement for disciplinary action, if warranted, after discussion with Chief Examiner. The responsibility for write up of the referral may be assigned to the EIC, with Oversight review.
 - d. Inquire of the Monitoring Examiner and Supervisor of Monitoring Examiner as to whether there are any current issues before the Department that need to be considered prior to issuance of the Final Report.

- e. Review of the “draft” Final Report by the Chief Examiner, prior to issuance, when significant findings are addressed.
- f. Sign and mail the Final Report.
- g. Distribute copies of Final Report to appropriate parties.
- h. Monitor for response from plan within 10-day confidential review period. If provided by plan, then attach response to Final Report that is sent to Department’s web site.
- i. Review response and discuss with EIC, as appropriate.
- j. Discuss any unresolved significant issues with Chief Examiner and determine if referral is needed to Office of Enforcement.
- k. Address any unresolved minor issues through a follow-up letter and/or as a compliance issue by the Monitoring Examiner.

PRE-EXAMINATION ACTIVITY

OBJECTIVES:

- A. Preliminary identification of potential risk areas, scope limitations and other factors affecting the examination.
- B. Notification of the examination to appropriate plan management and DMHC staff.
- C. Schedule survey (if one is needed) and dates of fieldwork.
- D. Inform plan of purpose of examination and schedule time with executive management.

PROCEDURES:

- 1. Review examination schedule for examiner assignments.
- 2. Examiner-in-charge ("EIC") reviews all examiner files, and DMHC public files for the period since the last examination, and makes follow-up inquiries of the Monitoring Examiner.
- 3. The EIC contacts licensing counsel, health analyst and HMO Call Center as to current business developments and records the result of these contacts and associated comments in the Administrative section of the work papers. The EIC will determine whether these comments will influence the examination procedures to be performed.
- 4. Review trends of historical interim financial statements for past year.
- 5. Perform analytic procedures on historic financial data. Discuss any concerns noted from review of these analytic procedures with Monitoring Examiner and Oversight Examiner. Address any unresolved concerns in the initial letter to the plan.
- 6. Perform materiality procedures to establish examination parameters.
- 7. Review the prior Preliminary and Final examination reports and the plan's responses to these reports.
- 8. Obtain and review the prior examination work papers. Use as a reference or guide only for current examination.
- 9. The EIC drafts a Planning Memo and time budget and arranges a meeting with the oversight examiner to discuss, as appropriate:
 - a. Issues from the prior examination.

- b. Material changes to plan operations since the last examination.
 - c. Concerns regarding any unresolved issues from prior examination or other areas of compliance.
 - d. Consideration of the effects of any new or amended sections to the Act, Rules and any accounting and/or auditing pronouncements.
 - e. Overall scope of the examination.
 - f. Expected total examination hours.
10. Prepare final Planning Memo.
 11. Prepare final Time Budget.
 12. EIC contacts the plan to set up the dates of the examination. This needs to be coordinated with the Oversight Examiner who will also be present on the first day of fieldwork. During this initial contact, the examiner should discuss:
 - a. Any current business developments of the plan.
 - b. The type, scope and timing of the examination.
 - c. Access to records and assistance by plan staff.
 - d. Working space and Internet access needs of the examiners.
 - e. "Entrance" conference to be scheduled with executive management of the plan on the first day.
 13. EIC sends a letter to the plan confirming date of fieldwork and requesting specific documentation from plan for review in the field and submission to the Department prior to fieldwork. This letter is based on results of Planning Memo, analytical review, etc. This letter is to request completion of all questionnaires, trial balance with lead sheets and claims data prior to start of fieldwork. Internal Control, Management Questionnaires and trial balance/lead sheet templates are to be sent via email attachment on the same day the letter is mailed and request that they be completed and returned prior to the fieldwork start date.
 14. EIC contacts plan after letter is sent to determine if plan contact person has any questions in regards to the specific requests made. EIC and plan may determine that a phone conference is appropriate to further discuss the requests and ensure the appropriate plan staff is consulted.

ANALYTICAL REVIEW PROCEDURES

Analytical review procedures are to be used in both the planning process and in the overall review phases of an examination. [Refer to SAS No. 56 and 96]

OBJECTIVES:

A. Planning

- To enhance the examiner's understanding of the plan's business, the plan's business transactions and those events that occurred since the last examination date.
- To identify areas that may represent risks relevant to the examination.
- To provide a basis for determining the nature, timing and extent of subsequent examination procedures.

B. Overall Review

To assist the examiner in assessing the examination conclusions reached and in evaluating the overall financial statement presentation.

PROCEDURES:

Planning

1. Prepare or obtain analytical review work sheet based on most recent annual audited financial statement and annualized financial report for the current examination period.
2. Review changes in the account balances on the balance sheet from the most current audited year to the current examination period.
3. Review changes in account balances on the income statement. Compare per member per month ("PMPM") amounts for the most current audited year with the PMPM amounts for the current examination period.
4. Review relationship between periods of the claims liability for incurred but not reported ("IBNR") to related expense.
5. Obtain a copy of the plan's operating budget or the plan's "comparison of budgeted amounts to actual" and review variances between the budgeted balances and the actual balances for the current and prior year, if available or applicable.
6. Perform or obtain financial ratio analysis and evaluate unusual historical trends or potential problem areas from most recent annual audit to most current examination date.

7. Compare financial ratios with industry statistics (prepared internally based on DMHC financial filings) and determine if significant deviations are relevant and should be investigated.
8. Review supplemental information filed with the DMHC Financial Report Format and determine that calculations are correct. Note any unusual items that require follow-up.
9. Determine if significant services are performed by an affiliate on behalf of the plan or if the plan is dependent upon an affiliate for funding. Determine if the plan is providing combined or consolidated financial reporting or providing separate financial statements of an affiliate. Consider if the examination should be expanded to include the affiliate under Section 1382 (a).
10. Incorporate findings into the examiner's assessment of risk (i.e., planning memo) and amend examination procedures (i.e., audit program), as appropriate.

Overall Review

1. After completion of the examination survey or fieldwork, compare the examination balances with those of the prior periods.
2. Perform additional analytical procedures, whenever applicable, that were not performed during the planning stage of the examination.
3. Evaluate whether all significant unexpected fluctuations and unusual items were adequately explained.
4. Determine that inquiries were properly addressed and sufficient evidence was obtained.
5. If examination determined that significant services are performed by an affiliate on behalf of the plan and/or that the plan is dependent upon an affiliate for funding. Consider if the examination should be expanded to include the affiliate under Section 1382 (a).

MATERIALITY

Materiality is one aspect of determining the audit risk in the planning process and in the overall final review phases of an examination. [Refer to SAS No. 47, 82 and 89]

OBJECTIVES:

- A. To establish a dollar amount beneath which a misstatement will not materially impact the examination results.
- B. To determine different levels of materiality based upon risk assessment for each area of the balance sheet.
- C. To establish the level of materiality to be used in determining which individual balance sheet and/or income statement accounts to examine.
- D. To establish a threshold that may materially impact compliance with tangible net equity ("TNE") requirements.

PROCEDURES:

- 1. Establish and document in the work papers a planning materiality level based on the calculations described below. The results of the calculations will provide the examiner with a range of materiality levels and the examiner should select from this range a materiality level that is appropriate to the risk level of the plan being examined.
 - a. Materiality level based on 1 percent of the larger of total assets or annualized revenues.
 - b. Materiality level based on the larger of total assets or annualized revenue using a materiality table.
 - c. Compare the results of the materiality calculation from a. and b., above, to a third materiality calculation based on 10% of excess TNE. [A plan with minimal "Excess TNE" will indicate higher risk and therefore, the examiner will need to set a lower materiality level. A large amount of "Excess TNE" will indicate less risk and therefore, a higher materiality level can be accepted.]
 - d. A tolerable misstatement is determined for computing sample sizes and making other scope decisions. Tolerable misstatement is calculated as the planning materiality amount (selected from a., b. or c.) multiplied by a factor of .75.
 - e. Determine a materiality level by account balance and by transaction amount.

2. At various stages during the examination and at the completion, an evaluation is made regarding the preliminary materiality level and whether to change the materiality level, expand examination procedures or take other action.

PLANNING MEMORANDUM

A planning memorandum is essential to summarize the examination planning process. It provides an assessment and justification for the areas requiring examination, which management and staff agree upon. [Refer to SAS No. 22, 47, 48, 56, 77 and 82]

OBJECTIVES:

- A. Document understanding of the plan's operations and business environment and the effects of significant changes, trends and current events on the plan's operations.
- B. Document preliminary risk assessment.
- C. Document the examination scope and develop the examination approach.
- D. Communicate to staff the examination approach prior to start of fieldwork.
- E. Aid in determination of staffing requirements and timing.

PROCEDURES:

1. Review all significant documentation from DMHC files, historical financial statements and prior work papers and examination reports (both routine and non-routine).
2. Review all requested information received from the plan in response to initial contract letter.
3. Prepare planning memorandum that addresses the following elements:
 - a. Business Environment:
 - Organizational structure, to include date of licensure
 - Related Parties/affiliates
 - Products
 - Enrollment (number, groups/individuals)
 - Providers (contract/non-contract; primary care/specialist; manner of compensation; network/staff model)
 - Service Area
 - Competition
 - Reinsurance/Underwriting
 - Premiums
 - Reserves
 - Management/personnel

- Technology
 - Internal Controls
 - Regulatory impact
- b. Annual audited report
- Material concerns from footnote disclosure.
 - Material adjustments from interim reports prepared by plan.
 - Impact of management letter issues.
- c. DMHC experience with plan
- Review of historical interim financial statements and footnotes.
 - Results of prior routine and non-routine examinations.
 - Concerns from other DMHC Divisions (i.e., Help Center, Plan/Provider Relations, Medical Survey).
 - Concerns from Monitoring Examiner.
 - Review of material modification and amendment filings since the last examination.
- d. Risk Assessment and Examination Approach
- Identify financial statement accounts and related business processes that have high risk of materially misstating the financial statements.
 - Identify statutory compliance areas that have high potential for noncompliance.
 - Consider the effects of any new or amended sections to the Act, Rules and any accounting and/or auditing pronouncements.
 - Determination of examination scope—full or limited.
 - Determination to use reports and/or working papers from plan's independent auditor and/or internal auditors for specific areas.
 - Brief description of procedures to be performed for each identified area.
- e. Materiality level
5. Discussion between EIC and Oversight Examiner for approval of Planning Memorandum and resulting examination program. EIC makes any revisions and finalizes the planning documents.
 6. Discussion between EIC and Oversight Examiner to number of examiners and level of experience needed to conduct examination, prior examination hours and examination approach/procedures so that EIC may develop Time Budget and work assignments.
 7. Sign off of Planning Memorandum by EIC and Oversight Examiner.

8. Send completed Planning Memorandum with Time Budget to Chief Examiner via email prior to start of examination. [Chief Examiner may be involved in setting the scope of the work to be performed for high-risk examinations.]
9. Schedule and hold meeting with examination team prior to start of fieldwork to discuss scope and timing of examination, specific issues related to the particular examination, work paper assignments and management expectations. Provide or make available a copy of the Planning Memorandum.

TIME BUDGET

The time budget sets forth the projected staff hours and work paper assignments based on the examination scope outlined in the planning memorandum. The staff hours is based on the number and level of experience needed to perform the examination. [Refer to SAS No. 1]

OBJECTIVES:

- A. Support for the level of effort presented in the risk assessment and examination approach of the Planning Memorandum.
- B. Identification of number and level of experience of staff examiners for efficient and effective performance of the examination program.
- C. Identification of staff hours by financial statement account, operational processes, statutory compliance and administrative activities.
- D. Management of the overall examination within budget.
- E. Provide for quick adjustment of examination scope or staff resources, when necessary.
- F. Identify areas where staff needs additional training and/or supervision.

PROCEDURES:

- 1. Oversight Examiner reviews prior examination program and prior examination hours and determines how it relates to the current examination approach. Prior hours are used as a guideline in developing the current budget. Provide projected start and completion dates to EIC.
- 2. Discussion between EIC and Oversight Examiner as to number of examiners and level of experience needed to conduct examination based on Planning Memorandum.
 - a. Additional hours required by inexperienced staff for performance of work assignments.
 - b. Additional hours required by EIC or experienced staff to provide training to inexperienced staff.
- 3. EIC prepares Time Budget and schedule of work assignments by staff examiner.
- 4. Sign off of Time Budget by EIC and Oversight Examiner.

5. Send completed Time Budget with the Planning Memorandum to Chief Examiner via email prior to start of fieldwork.
6. Schedule and hold meeting with examination team prior to start of fieldwork to discuss scope and timing of examination, specific issues related to the particular examination, work paper assignments and management expectations. Provide or make available a copy of the Time Budget.
7. EIC and Oversight utilize Time Budget to monitor progress of examination. Revisions are made, as identified, for scope changes or staffing resources.
8. EIC and Oversight compare actual time with Time Budget to determine specific areas in which the staff may need additional training or supervision.

EXAMINATION SURVEY ACTIVITIES

OBJECTIVES:

- A. Plan overall strategy for the conduct and scope of the examination.
- B. Obtain an overall understanding of the plan's organization structure, accounting systems and controls, and the types of documents and records generated by the plan.
- C. Identify risk areas upon which the major portion of exam work should be focused.

PROCEDURES:

- 1. Hold entrance conference with executive/key management to discuss the examination process, obtain understanding of plan organizational structure and operations, types of products, affiliate arrangements or transactions, and any other major issues.
- 2. Review and inventory the financial records and other documentation requested in the notification letter to the plan. Discuss with plan representatives, as appropriate.
- 3. Review complaint and grievance logs of plan and related complaint information from DMHC for any systemic or pattern of issues that may impact procedures for review of claims, provider capitation payments, monitoring of capitated providers, or other areas.
- 4. Prepare lead sheets and trial balance from mapping schedule and bridging entries, only if plan is unable to prepare.
- 5. Perform risk assessment based on review of completed internal control questionnaire, management questionnaires and all other documents received.
- 6. Determine if cash accounts are reconciled.
- 7. Determine if supporting documentation exists for each of the claims classifications on the DMHC Financial Report Form.
- 8. Gain an understanding of inter-company/affiliate transactions. Include a review of the general ledger to determine if the accounts are clearing regularly.
- 9. Review lead sheets of balance sheet accounts identified during planning process and select those to be examined.
- 10. Review and summarize Board of Director Minutes.

11. Revise materiality, planning memorandum, time budget and examination program, as necessary.
12. At the completion of the survey, the EIC sends a follow-up letter to the plan confirming the date when the examination field work will begin and include any requests for additional documentation and/or explanations, as determined from the results of the survey.

REPRESENTATION LETTERS

Representation letters are to be obtained as part of the examination process. [Refer to SAS 12, and 85]

OBJECTIVES:

- A. Reduce the risk of misunderstandings between the plan management and the Examiners.
- B. Written representations provide confirmation and/or evidential matter of representations made by plan management to the Examiners.
- C. Written representations provide third party evidential support.
- D. Identify and/or confirm litigation, claims and assessments for accrual or disclosure in financial statements.

PROCEDURES:

1. INQUIRY LETTER TO LEGAL COUNSEL [Refer to SAS 12]

- a. At the start of the examination, obtain a listing and evaluation of litigation, claims and assessments from the plan. Review and document applicable documents in plan's possession to support its assessment.
- b. Request the plan prepare a letter to each attorney (as identified on the list from a. above and whether they are "inside" or "outside"), who performed services for the plan during the current fiscal year, to obtain a letter of audit inquiry. The letter is to be mailed by the examiner (not by the plan). EIC is to provide the plan with a sample letter.

The letter is to request the attorney to report on matters that existed at the examination date and during the period from that date to the date of the attorney's response that have changed since the attorney sent a similar response to the Independent Auditors who performed the plan's most recent year-end audit.

- c. Obtain written representation from the plan that FASB-5 requirements were considered in regards to accrual or disclosure of litigation, claims and assessments in the financial statements. [Statement contained in General Representation Letter]
- d. Determine if a materiality level should be set for inquiry as to these contingencies.
- e. Determine if it is appropriate to accept oral representations from the plan's attorney.

- f. Determine the impact on the examination when an attorney does not respond to the audit inquiry.
- g. Determine that appropriate liability reserve is recognized in the balance sheet for those legal cases that are evaluated to have potential loss to the plan and/or that proper footnote disclosure is made in the financial statements. In addition, determine that any legal fees disclosed in responses from counsel are adequately accrued as a liability or paid.

2. MINUTES CERTIFICATION

- a. After review of minutes, the EIC is to obtain certification from the plan on its letterhead and signed by the Secretary of the Board that all minutes for the specific timeframe were provided for review. EIC is to provide plan with a sample certification.
- b. If the plan does not have minutes or has inconsistent meeting dates, then request the plan to provide its By-laws for the Board Meeting requirements. Determine plan's compliance with its By-laws. Failure to maintain minutes and/or comply with its By-laws is an indication of administrative capacity concerns.

3. GENERAL REPRESENTATION LETTER FROM PLAN MANAGEMENT

- a. Obtain written representations from plan management that relate to financial statement presentation, completeness of financial records and other documentation, disclosure of certain information (i.e., affiliate transactions) and subsequent events. These representations are to be on plan letterhead, dated the last day of fieldwork and signed by the CEO and CFO. EIC is to provide the plan with a sample letter.
- b. Determine if any additional written representations are necessary.
- c. Evaluate any inconsistencies between the representations made by plan management and evidence obtained during the exam.
- d. Consider the impact on the examination should plan management refuse to provide written representations, as follows:
 - If after reading the content of the letter, plan management states they cannot sign, then the EIC should request that management write, at the end of the letter, the reasons/exceptions why the letter in its present form cannot be signed. Plan management should then sign the letter below the justification.
 - If plan management refuses to sign any form of the letter, then the EIC should cite the reasons given in the work paper and discuss with the Oversight Examiner. Determination must be made as to impact on the examination and disclosure, if any, in the Department's written reports.

4. CLAIMS PAYABLE/IBNR REPRESENTATION LETTER

After review of claims payable/IBNR, the EIC is to obtain a certification from the plan on its letterhead and signed by the Claims Manager and CFO that all claims payable and pending, either processed or unprocessed, for the specific timeframe were provided for review. EIC is to provide Plan with a sample certification.

5. TRADE PAYABLES REPRESENTATION LETTER

After review of trade payables, the EIC is to obtain a certification from the plan on its letterhead and signed by the Accounts Payable Manager and CFO that all trades payable and pending, either processed or unprocessed, for the specific timeframe were provided for review. EIC is to provide Plan with a sample certification.

BOARD OF DIRECTORS MINUTES

OBJECTIVES:

- A. Identify significant decisions made by the Board of Directors.
- B. Determine whether the Board of Directors has sufficient control over the overall operations of the plan.
- C. Determine whether the Board of Directors is authorizing significant purchases, disbursements and hiring decisions made by the plan.

PROCEDURES:

Perform the procedures during the Examination Survey or first week of fieldwork.

- 1. Review the Board Minutes for the prior fiscal year and for the current year, up to the date of fieldwork.
 - a. If the Board Minutes are not maintained or have inconsistent timeframes. Request a copy of the By-laws. Determine compliance with By-laws and write up as appropriate in the work papers.
 - b. If the Board Minutes are not current, then request that the plan prepare them and provide for review by the examiner. If plan does not comply, then document in the work papers.
- 2. Document the review of the Minutes by summarizing in a work paper. Begin with the earliest date in the review period and end with the most current date. Document all decisions made by the Board. The date of the Board Meeting should be written in the left hand column of the work paper. The summary of the minutes is written to the right.
- 3. Determine whether the Board discussed the results of the most recent independent audit. This may entail the attendance at a Board meeting of a representative of the audit firm, a review of the audited statements and the management letter. If the Board did not review the results of the audit, note this in the work papers.
- 4. Document all significant discussion noted in the Minutes, even though no decision resulted. If no significant issues were recorded in the Minutes, then state "Usual business". The following are suggested areas to document: changes in officers/directors; related-party transactions; changes in bank accounts; significant purchases; mergers/acquisitions; litigation; debt/guarantee agreements; changes in capital stock; declaration of dividends or returns of capital to shareholders; leases; significant events.

5. Refer to this work paper whenever an examination area indicates that Board of Director approval should have been obtained prior to an action by plan management. Any exception should be documented on the applicable work paper, not on the Board Minutes summary work paper.
6. If the composition and number of Board Members, or the number of Board Meetings (for example, no Annual Board Meeting has taken place following the fiscal year-end), refer to the By-laws of the plan for the plan's intentions.
7. Review the minutes from meetings for the following committees: Audit Committee, Finance Committee and/or Executive Committee, as applicable.

WORK PAPER LAYOUT

Work papers document the procedures followed, the tests performed, information obtained and conclusions reached during the examination. Work papers document how the examiner evaluated the sufficiency and competence of evidence gathered and resolved any conflicting information. [Refer to SAS 12, 19, 22, 31, 39, 41, 45, 47, 54, 55, 56, 57, 59, 60, 61, 67, 77, 78, 80, 85, 89, 95, 96, and 99]

OBJECTIVES:

- A. Record the work performed and conclusions reached by the examiner.
- B. Demonstrate that audit documentation is sufficient to show:
 - The accounting records agree or reconcile with the financial statements or information reported on.
 - That abstracts or copies of significant contracts or agreements reviewed by the examiners to evaluate the accounting for significant transactions are provided as evidence.
 - That tests of operating effectiveness of controls and substantive tests of details involving inspection of documents or confirmations included an identification of the times tested (how selected).
 - The examiner team understanding of the evidence obtained and the nature, timing, extent and results of the auditing procedures performed.
 - The examiner performed and reviewed the work.
- C. Demonstrates the work was performed in accordance with standards of the DMHC, and with GAAS and GAAP.
- D. Provide a basis for review by Supervisor of the work performed and evaluation of the job performance of the examiner staff.
- E. Provide a basis for support of the examination report.
- F. Provide a record of evidence for any referrals to the DMHC Office of Enforcement for administrative action.

PROCEDURES:

1. WORKPAPER COMPILATION

Work papers should be compiled in notebooks under the following categories:

- a. Statutory Compliance

b. Administration

- Correspondence
- DMHC Financial Reports Forms
- Examination Program
- Internal Control Questionnaire
- Management Questionnaires
- Planning Memo
- Time Budget and Time Sheets
- Trial Balance
- Adjusting Journal Entries
- Index of Exceptions

c. Assets and Liabilities (or, separately if large number of accounts)

d. Preliminary and Final Reports with Plan Responses

2. WORKPAPER FORMAT

The format of the sample work papers should be followed in the interest of uniformity. Work papers may be expanded or adapted to suit specific situations.

a. Work papers must be neat and legible.

b. Tick-Marks must be defined on the work paper. Exceptions should be tick-marked in RED. Corrective action or recommendations should be tick-marked in BLUE. Other tick-marks may be made in other colors if it adds clarity to the work paper.

c. Indexing of the work papers should be as follows:

- Lead sheets should be prepared for each balance on the DMHC Financial Report Form and indexed to the working Trial Balance for the examination. The indexing is accomplished by the assignment of the alphabet, beginning with Cash as "A" placed in the lower right hand corner of the work paper. If a foldout work paper is used, the indexing will appear on the outside of the folded page in the lower right hand corner.
- Comparative sheets should be indexed by using the lead sheet letter and a number, with no numbers skipped (e.g. A-1, A-2, A-3, etc.).
- Supporting work papers that document the comparative sheets should be indexed by using the lead sheet letter and two numbers (e.g., A-1-1, A-1-2, A-1-3, etc.)
- Narrative work papers or Checklists will always be assigned the number "1". (e.g. Cash Checklist will be work paper "A-1")

All general ledger accounts listed on the DMHC Financial Report Form balance sheet are assigned a permanent lead sheet letter. For example, if the plan has three Cash accounts, and maintains a general ledger account for each bank account, then each General Ledger ("G/L") account will be indexed A-2 through A-4, with the checklist being A-1. If there are four work papers which support the first bank account, they will be indexed A-2-1 through A-2-4.

It is more efficient to delay numbering the supporting work papers until the series is completed.

d. Cross-References

All work papers must contain necessary cross-references to supporting or related work papers. If an amount in a schedule or analysis is detailed or explained on another work paper, reference should be made to such work paper. Also, the detail or explanation on the second work paper should be cross-referenced to the first work paper. In addition, if it adds clarity to the cross-reference, use the prefix "to" and "from".

3. LEAD SHEETS

- a. Each DMHC Financial Report Form balance should be supported by a Lead Sheet that details all the component G/L accounts comprising the balance on the DMHC Financial Report Form.
- b. The lead sheets will have the following standard column headings:

G/L No.	Account Name	W/P No.	Balance per G/L @ B/S date	Bridging Entries	Balance per F/S @ B/S date	Examination Adjustments	Balance per Exam @ B/S date
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- c. All amounts on all work papers, including the Lead Sheets, are to be rounded to the nearest dollar. If the Total on the Lead Sheet does not agree to the DMHC Financial Report Form balance, due to rounding, the difference should be included after the listing of the accounts and before the total line, and labeled "Rounding".
- d. Lead sheets are prepared in the Trial Balance template to include all G/L accounts, whether or not account balance work is performed. If no account balance work for that Lead sheet area is performed, then a tick-mark is placed by the account on the Trial Balance with a justification written as to the reason (e.g. "Not within scope of examination"; "Immaterial balance; review of the G/L shows no activity.") If account balance work is performed for some accounts listed on the Lead sheet, then a tick-mark

is placed by those accounts on the Lead sheet that are not reviewed and a justification provided.

4. COMPARATIVE SHEET

- a. There should be one Comparative Sheet for each account listed on the lead sheet unless one of the following conditions exists:
 - There is a statement written on the Trail Balance or Lead sheet explaining why no examination procedures will be performed on that account; or
 - The examiner has combined several accounts listed on the Lead Sheet onto one Comparative Sheet. This situation may arise when examining, for example, Claims and IBNR accounts or Fixed Assets. In such situations, list each G/L account and balance with the combined total labeled “Balance per Financial Statement.” Be sure to cross-reference.
- b. If the account is a "debit" account (e.g. an asset account), put "DR" at the top of the column for balances. If the account is a “credit” (e.g. a liability account), put "CR". If a debit account has a credit balance, or a credit account has a debit balance, (e.g. a liability account with a debit balance), enclose the balance in parentheses <XX>.
- c. The general layout of the Comparative Sheet for an asset account is as follows:

	DR
Balance per Financial Statements @ (Exam Date)	XX, XXX, XXX
Balance per Exam @ (Exam Date) (cross-reference)	<u>XX, XXX, XXX</u>
Difference	<u>XX, XXX</u>

- d. The “Purpose” of the account is to be stated on the Comparative Sheet, as follows:
 - Describe how the account is used, state what types of transactions are recorded in the account, and disclose any other information relevant to understanding the account. Also indicate if there is another account related to this account (e.g. a contra account) and include the account title and G/L#. Be sure to cross-reference.
 - If plan personnel state that the account is used for a purpose different to the one the examiner has documented, do not include this in the "Purpose", but note it as an Exception.
- e. The “Procedures” performed in review of the account is to be stated on the Comparative Sheet, as follows:

- List the plan personnel with position title that was interviewed regarding the account.
 - List each examination procedures performed to verify the balance in the account. Clearly state the source of the data provided (i.e., from an adjusting journal entry; from an invoice). Clearly state the verification work performed (i.e., review paid invoices for the period 2/1/04 to 3/31/04).
 - Provide clarity as to the procedures performed by specific identification of the contract or other supporting documentation reviewed (i.e., name of document, date, brief description of content). Do not include copies of any documents that are not relevant.
 - The extent and scope of testing should be stated when performed. In the review of Premiums Receivable 10% review of large balances may result in 90% of the account balance being reviewed. The supporting work papers should disclose the support for the testing performed.
 - If all of the procedures cannot be listed on the comparative sheet, begin the list of procedures on the comparative sheet and cross-reference to a second work paper where the listing of examination procedures continues.
 - Do not list procedures that are in the examination program, but merely cross-reference to the examination program. (e.g., "See examination program")
 - Do not list procedures that are listed on related work papers in the series, but merely cross-reference to them. (e.g., "For other procedures see W/P XX".)
- f. The "Examination Balance" presented on the Comparative Sheet is to be supported, as follows:
- Cross-reference to the work paper where the detail of the Examination Balance is supported or calculated.
 - If, as a result of the examination procedures, a Difference between the Financial Statement balance and the Examination Balance exists that is below the Materiality level, and after considering the note in paragraph g. below, merely state that the plan's balance is accepted as the Examination Balance or include the immaterial difference in calculating the Examination Balance. Provide a narrative statement on the work paper where the Difference was calculated. Also, cross-reference this statement to the Examination Balance at the top of the Comparative Sheet.
- g. The "Difference" presented on the Comparative Sheet is to be supported, as follows:
- A material difference that results between the Financial Statement balance and the Examination Balance is to be supported by an explanation, or a detailed listing of the components of the Difference. If the Difference is comprised of more than one item the latter method is necessary. Each item should be cross-referenced to the work paper that contains the support. If necessary continue the details of the Difference on a subsequent work paper and cross- reference to the appropriate work paper.

- If there is a material difference between the Financial Statement balance and the Examination Balance an AJE or RJE must be considered. The journal entry should be shown on the Comparative Sheet and identified under “AJE” or “RJE”. If the explanatory paragraph is too long for the Comparative Sheet continue on a subsequent work paper and cross-reference, as appropriate.
 - If the calculated Difference is below the materiality level, but if when added to Differences in accounts within the same Financial Statement classification results in a material difference, then document the AJE or RJE on the Comparative Sheet.
 - There will be occasions when the level of materiality of the exception is just below the materiality level yet, because of certain circumstances, the examiner is uncertain whether to make the AJE or RJE. If the EIC is available he/she should be consulted. If the EIC is not available the exception should be made on the Comparative Sheet, and the EIC will determine later whether the journal entry should be made.
- h. The “Exceptions” presented on the Comparative Sheet is to be supported, as follow:
- Exceptions should be stated in narrative format with sufficient detail to be directly incorporated into the Index of Exceptions and Preliminary Report. If the exception is due to a violation of a Section or Rule, then cite the appropriate Section or Rule number.
 - Any Exceptions noted on supporting work papers should be cross-referenced to the work paper. Do not duplicate any narrative on the Comparative Sheet.
- i. If the examiner concludes from the work performed that there are no differences or exceptions noted, then a “Conclusion” is presented on the Comparative Sheet that states such finding.

5. SUPPORTING WORKPAPERS

- a. The work papers that follow the Comparative Sheet are referred to as the Supporting Work papers, and should be prioritized as follows:
- Continuation of Procedures
 - Continuation of Exam Balance, Difference and/or Exceptions
 - Schedules or analyses of amounts that comprise the Examination Balance
 - Supporting documents or part of supporting documents that are relevant to provide evidence of the examiner’s findings (e.g. copy of a page of a contract, where the language supports an exception).
- b. Plan-generated supporting schedules should be used in determining the examination balance. Procedures must be performed to satisfy the examiner that the amounts on the plan’s schedule are reliable.

- c. Plan-generated schedules are to be labeled "PBP" (prepared by plan). A description of what this document demonstrates or supports is to be included by the examiner or the Plan.
- d. If there is a section of a supporting schedule that is not relevant to the purposes of the work paper, then strike it out.
- e. Not all work papers present an analysis of a component of the financial statement or G/L balance and do not need to follow the Comparative Sheet format. The examiner may be testing the plan's records for internal controls or statutory compliance. Such supporting work papers should clearly set forth the following:
 - The purpose of the work paper
 - The procedures performed
 - The evidence obtained or reviewed
 - A statement of findings and/or a conclusion
 - Identify any exceptions

6. FINALIZING THE WORK PAPERS

- a. Discuss all differences/exceptions/findings with appropriate plan staff to ensure no misunderstandings in documentation provided by the Plan and/or in communicating the concerns by the examiner.
- b. Review the work papers for completeness and clarity.
- c. Review mathematical calculations to ensure accuracy (i.e., footing, cross-footing).
- d. Determine that all cross-referencing is completed.
- e. Carry forward Examination Balance and Difference (if any) to the Lead Sheets and working Trial Balance.
- f. Complete the work paper with initials by the examiner that prepared and the date prepared in the lower right-hand corner.
- g. After review by the EIC and/or Oversight Examiner, their initials and date reviewed are placed in the lower right-hand corner of the work paper.
- h. Place in completed work paper notebook with "red flag" post-it for differences and exceptions noted.

7. RETENTION OF WORK PAPERS [Refer to Rule 1009]

The Final Report and supporting work papers are retained at the DMHC office location upon the conclusion of the examination. The DMHC maintains the Final Report and work papers for a minimum period of five years from the date of the Final Report's release or until release of the next Final Report, whichever is later. Thereafter, the Final Report and work papers are destroyed.

The Final Report and supporting work papers that result in DMHC enforcement investigations and actions are to be retained for a minimum of five years from the date the matter is closed. Thereafter, the Final Report and work papers are destroyed.

INTERNAL CONTROL

A plan's internal control system is reviewed as part of the examination process. [Refer to SAS 55, 60, 61, 65, 78, 94 and 96]

OBJECTIVES:

- A. Obtain a sufficient understanding of the plan's internal controls designed to reasonably assure reliability of financial reporting, efficiency and effectiveness of the financial operations, and compliance with the Knox-Keene Act and related regulations. This may be accomplished by the review of the following:
 - Control environment – to determine the organizational tone.
 - Risk assessment – to determine how plan management identifies risks related to the possible occurrence of errors for particular transactions, events and balances.
 - Control activities – to determine that plan management has policies and procedures in place that provide information processing, physical controls and segregation of duties.
 - Information and communication – to gain an understanding of the accounting records and accounting processes; and, to determine how this information is communicated to plan personnel.
 - Monitoring – to gain understanding of how plan management oversees its controls and if they are effective.
- B. Assess the control risk to determine the nature, timing and extent of substantive testing during the examination.

PROCEDURES:

- 1. Obtain and review Internal Control Questionnaire completed by plan.
- 2. Review prior work papers.
- 3. Make inquiries of appropriate management, supervisory and staff personnel.
- 4. Determine impact, if any, on Examination Program and Planning Memo and make appropriate changes.
- 5. Assess the internal controls through observation, and examination procedures as they are applied during the examination process.
- 6. Review Management Letter from plan's independent CPA's most recent annual audit.
- 7. Obtain and review written documentation, as appropriate.

8. Observe the processing of transactions, as appropriate.
9. Document understanding of Internal Controls and identify and provide support for weaknesses noted.

MANAGEMENT QUESTIONNAIRES

An assessment of the plan's management and Board of Directors is performed as part of the examination process. The questionnaire contains interview questions to be asked of the following:

- Chief Executive Officer
- Board Member
- Marketing Director
- Chief Financial Officer
- Chief Information Officer

OBJECTIVES:

- A. Assists in planning of examination as to risk assessment and understanding internal controls.
- B. Assists in the evaluation of the plan's management staff as to compliance with administrative capacity. [Refer to Section 1367 and Rule 1300.67]

PROCEDURES:

1. Obtain and review completed Management Questionnaires prior to or at the beginning of the examination fieldwork.
2. Identify areas of the questionnaire that are not fully completed or additional questions that arise for clarity, etc.
3. EIC and/or Oversight should schedule a personal interview with each member of management to discuss and/or obtain any additional clarification. It is preferable to perform the interviews in person, but they may be done via phone.
4. Identify any areas of concerns and document discussion with appropriate management position. Identify any exceptions with "Red Check" mark, as appropriate.

SECTION II. ROUTINE REGULATORY EXAMINATION FIELDWORK

CASH

OBJECTIVES:

- A. All cash reflected in the balance sheet exists and is owned by the plan.
- B. Cash balances reflect a proper cut off of cash receipts and disbursements.
- C. Restricted cash is identified and reported as a non-current asset.
- D. Cash balances are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions. Any restrictions on the availability of funds are properly disclosed (i.e., significant credit risk arise from cash deposits in excess of federally insured limits).

PROCEDURES:

1. Complete the Cash Checklist by interviewing appropriate plan personnel.
2. Document the purpose of each cash account. Describe how the plan uses the account including the types of transactions, the source of funds deposited and the destination of disbursements. Also, include the name of the bank and the bank account number.
3. If there are numerous transfers between the plan's various cash accounts, then prepare or obtain an overview of the cash system of the plan. Include a flow chart if it adds clarity.
4. Determine if further procedures are required and if so, then determine the most feasible method for verifying the cash balances. Suggested method is as follows:

Prepare a "Vouching" work paper for each bank account for the month of the examination date, as follows:

a. Cash Disbursements

- Trace G/L cash disbursement entries to CDJ/check register.
- Trace miscellaneous items in G/L to supporting documentation.
- All disbursement bank accounts: compare the check issue dates and the dates that the checks cleared the bank to determine if checks are being held. If checks are being held, the plan may have a Cash Flow problem. Test more checks in different months if plan appears to have a Cash Flow problem.

- Inspect where blank check stock is kept for all checking accounts. Inspect where processed checks are maintained until they are released (mailed) [should be stored in a vault].

b. Cash Receipts

- Trace totals from CRJ to G/L.
- Trace 3 days cash receipts from supporting documentation to CRJ.
- Trace 3 days deposit slips to bank statement.

c. Check Review

Account for each check in a sequence of checks. The number of checks reviewed will be between 100 and 400 depending on the volume of checks. For large dollar amount checks and/or unusual transactions, review payee, endorsement, entry in check register, and supporting documentation.

5. For each checking account, review and make comment in the work papers that balance at the examination date was verified against the bank statement and the bank reconciliation prepared by the plan. Also, perform and state the following procedures:

- a. Review bank statement for unusually high items and investigate transactions for undisclosed items, such as inter-company transactions or liabilities.
- b. Review the bank reconciliation. Verify that the method used is the "Reconciliation of Bank to Adjusted Bank Balance and G/L to Adjusted G/L Balance".

If the plan uses another method to reconcile (e.g. reconciling the bank to the general ledger or proof of cash) or the plan has not reconciled the account balance, the examiner should prepare a bank reconciliation using the "Reconciliation of Bank to Adjusted Bank Balance and G/L to Adjusted G/L Balance" method.

- Trace the G/L balance to the balance per cash lead sheet and general ledger and trace the bank balance to the bank statement.
- Trace the deposits in transit to the following month's bank statement and ascertain whether the time lag is reasonable. Verify cutoff of cash receipts.
- Review and explain all material reconciling items and trace to supporting documents. Verify that reconciling items were resolved and properly posted to the general ledger in a timely manner.
- Review any adjustments made to the general ledger balance by the plan in preparing the financial statement and determine the effect of such adjustments on the reconciliation.
- Verify the mathematical accuracy of the reconciliation.

- c. Trace the last check issued from the check register to the outstanding checklist. Verify that the first check in the following month's check register is the next check in sequence. Verify cutoff of cash disbursements.
 - d. Obtain and review the listing of outstanding checks, as follows:
 - Verify the mathematical accuracy of the listing of outstanding checks, if prepared manually.
 - Trace checks listed on the outstanding checklist to either the following month's bank statement (if cleared) or the following month's outstanding checklist (if still outstanding) and check copies (or check register, if no copies are maintained).
 - Review for stale checks and the plan's policy for handling them. Stale checks are to be set up as a liability until the payee is located or escheatment takes place. Determine that the procedures address proper Escheatment to the State Controller for unclaimed funds.
 - Investigate any outstanding checks not cleared within a reasonable period of time and ascertain that the disbursement is proper. Trace to check copies, if appropriate.
 - e. Confirm bank account balances only if ownership of the account is in question.
 - f. Review copies of signature cards to verify that only authorized signers are signing checks and/or initiating wire transfers. Review Board minutes for authorized persons. Signatories are to be employees or officers of the Plan.
6. Obtain from the plan or prepare a Bank Transfer Schedule, as follows:
- a. Provide the following column headings:
 - Name of disbursing bank
 - Check or transfer number
 - Amount
 - Date transferred out per G/L
 - Date transferred out per bank
 - Name of receiving bank
 - Date transferred in per G/L
 - Date transferred in per bank
 - b. Review the cash receipts and disbursement journals, bank statements and related paid checks for the last ten days before and the first ten days after the examination date and

- list, on the Bank Transfer Schedule, all transfers between the plan's bank accounts on the transfer schedule.
- c. Review the schedule of transfers and determine that both sides of the transfer are recorded timely, and in the proper period.
7. If plan delegates this function to an affiliate or external party, then perform the following:
- a. Obtain and review executed contracts.
 - b. Determine the services performed on behalf of the plan and level of discretion allowed by plan.
 - c. Determine the guidelines/parameters set-forth by the plan and compliance by the affiliate or external party.
 - d. Determine how the plan monitors performance and compliance with these contracts.

INVESTMENTS

OBJECTIVES:

- A. Proper internal controls are instituted over its invested assets to prevent defalcation and/or loss.
- B. Only investments owned by the plan are reported on the balance sheet and physical evidence of ownership is maintained by the plan.
- C. Invested assets are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions. [Refer to FAS-115, 124 and 133; SAS-55, 67, 81 and 92]
- D. Adequate disclosure is made for Invested assets that are assigned or pledged.
- E. Investment income/loss is calculated and reported correctly.
- F. Investment complies with the requirements of Section 1346 (a) (11).

PROCEDURES:

Complete the Investment Checklist by interviewing appropriate plan personnel. Examiner is to determine if additional procedures are required and if so, then determine the most feasible method for verifying the balance. Suggested method is as follows:

- 1. Obtain and review the plan's Investment Policy. Prepare a summary to outline the plan's investment objectives and asset allocation guidelines. Determine if policy addresses compliance with applicable state regulations. Determine if policy provides guidelines for derivative investments.
- 2. Determine the responsible party for purchasing and selling investments. Discuss with him/her the procedures relating to investments. If plan delegates this function to external parties, then perform the following:
 - a. Obtain and review executed contracts for investment managers/consultants.
 - b. Determine the services performed on behalf of the plan and level of discretion allowed by plan.
 - c. Determine the guidelines/parameters set-forth and compliance with Investment Policy.
 - d. Determine how the plan monitors performance and compliance with these contracts.

3. Examine board or investment committee minutes, for at least one-year, to determine the following:
 - a. Investment purchases/sales are properly authorized.
 - b. Undisclosed investments as of the examination date.
 - c. Performance of investment managers/consultants under contract are authorized, monitored and evaluated.
 - d. Investment portfolio is reviewed with the guidelines set forth in the investment policy.
 - e. Identification of any financial concerns requiring investigation.
4. Inspect all investments maintained on-site (i.e., stock certificates, bonds) to ensure they are under dual control and adequate safe keeping.
5. Determine whether the Investments are owned by the plan and in the plan's name.
6. Review executed custodial agreements and determine the following:
 - a. Services performed.
 - b. Adequate safeguards to ensure that the plan is indemnified in the event of loss or destruction of the plan's securities. [Sample wording: a) Custodian is obligated to indemnify the plan for any loss of securities of the plan in the bank or trust company's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction; or, b) in the event that there is a loss of securities for which the bank or trust company is obligated to indemnify the plan, the securities shall be promptly replaced, or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced.]
7. Review investment reconciliation of G/L to subsidiary and subsidiary to supporting documentation performed by plan staff to determine they are performed timely; reviewed by a position of authority; and, reconciling items are investigated and resolved timely. Investigate any unusual/large reconciling items and determine resolution.
8. Prepare a narrative describing the overall content of the investment account and the procedures in place regarding plan's transactions.
9. Obtain custodial statements or other supporting documentation.

10. Obtain a confirmation from the custodian and/or a cutoff statement of the securities from the broker of the applicable agent, only if confirmation appears necessary.
11. Review reconciliation of subsidiary ledger to custodial statement or other supporting documents (i.e., bank statements). Since securities are reported at different values in the books than in the statements, be sure to match all investments listed in the subsidiary ledger to the statement first by CUSIP# (to identify matching security), then by # of units (par value for bonds, # of shares for stocks) or cost.
12. Determine market value and ratings of securities. Verify that the plan is using competent published sources to obtain prices for securities reported at fair market value. Obtain from the plan a description of the pricing methodology used by the source or the website of the source. Trace prices through competent published sources. If rating is below an "A", implement an investigation as to the reasonableness of the investment in the Plan's portfolio.
13. Investments that have no determinable market value (i.e. investments in subsidiaries, or another company that does not trade on a financial market) should be supported by documentation that attests to the value reported.
14. Review subsidiary investments as follows:
 - a. Request a description of all plan subsidiaries, including the percentage ownership, type of business, and how the plan accounts for the subsidiary investment in the financial statements (consolidated or equity method). [Note: FAS 94 requires that all majority-owned subsidiaries be reported on a consolidated basis.]
 - b. Review the stock certificate for each subsidiary to verify the number of shares owned by the plan and that the certificate is actually in the plan's name.
 - c. Obtain and review the most current financial statements for each subsidiary. Determine that the dollar value of each subsidiary investment agrees with the proportionate percentage of equity reported on the subsidiary's balance sheet (i.e. if the subsidiary is 60% owned, the plan's reported investment in that subsidiary should be approximately 60% of the Equity reported on the subsidiary's Balance Sheet). Investigate any material differences.
 - d. Determine or require the plan to demonstrate that each subsidiary investment is reported in accordance with GAAP on the DMHC Financial Report Forms (using the Equity or Consolidated method as appropriate).
 - e. If the subsidiary is a regulated entity (i.e. an insurance company), then the subsidiary investment should be excluded from the calculation of TNE and the Required TNE.

15. Obtain or prepare a schedule of amortization of premium and discount. Determine they are properly computed. Ensure that these amounts are properly accounted for on the financial statements.
16. Evaluate foreign investments by requesting the plan's methodology for controlling "currency" and "sovereignty" risk.
17. Review the plan's Derivative Holdings/Policy with Respect to Derivatives and perform the following:
 - a. Obtain a listing of the plan's derivative holdings as of the exam date.
 - b. Inquire as to the nature of these derivative instruments, including:
 - The type of instrument,
 - Whether the instrument is being used as a hedge,
 - What are the underlying, notional amounts, payment provisions,
 - A description as to how the derivative works (if necessary, the Examiner should perform internet research to obtain a better understanding of the nature of the derivative instrument)
 - c. Assess the degree of risk inherent in the instrument, and whether such an instrument is an appropriate investment vehicle for a health care service plan, pursuant to Section 1346 (a) (11).
 - d. Review the plan's derivative holdings for compliance with FAS 133 (Accounting for Derivative Instruments and Hedging Activities).
18. Determine or require the plan to demonstrate compliance with appropriate GAAP; and Section 1346 (a) (11), including Article 3 (commencing with Section 1170) of and Article 4. (commencing with Section 1190) of, Chapter 2 of Part 2 of Division 1 of the California Insurance Code. [See www.insurance.ca.gov legal information/insurance code]

INVESTMENT IN A SUBSIDIARY OF THE PLAN

OBJECTIVE

- A. To determine that the plan's reported investment in its subsidiary is properly reported and valued in accordance with GAAP. [Refer to ARB-43, ARB-51, FASB-94 and SFAS 141]
- B. To determine that the plan's ownership of the subsidiary is reported on the DMHC Financial Report Form by the equity method (i.e. as a long-term investment) or as a consolidating entity. [See Rule 1300.84(f)]

PROCEDURES

- 1. Interview appropriate plan personnel and review any written documentation maintained by the plan to gain an understanding of how the plan's ownership interest in a subsidiary is recorded to the plan's financial statements. Document understanding in the work papers.
- 2. Determine the extent of the procedures to be performed based upon the materiality of the subsidiary's equity to the plan's equity.
- 3. Set up a separate notebook for the work to be performed of the Subsidiary. If the subsidiary is recorded by the equity method (i.e., Investment account), then leave the Lead Sheet in the asset section of the plan's work papers. Cross-reference the Lead sheet to the appropriate Notebook volume.
- 4. In the Subsidiary Notebook, present work papers for the following:
 - a. Purpose of the work.
 - b. List the procedures to be performed.
 - c. The balance sheet of the subsidiary at the examination date, as prepared by the plan.
 - d. To support the procedures performed.
- 5. If presentation on the DMHC Financial Report Form is by the equity method, then verify that the equity balances of the subsidiaries, in aggregate (less portions of subsidiaries not owned by plan), agrees with the Long Term Investment balance. If it does not agree, then request a reconciling schedule from the plan.
- 6. Select for review those balance sheet accounts of the subsidiary that, if misstated, may result in an overstatement of the plan's asset value of the subsidiary.

7. If the subsidiary reports claims liability and the EIC has determined that the plan's claims liability (which uses the same claims processing system) is understated, then recalculate the subsidiary's claims liability. The claims system does not have to be re-tested.
8. If the major assets of a subsidiary are securities or cash investments, then perform Examination procedures for Cash/Investments, as appropriate.
9. Intangibles assets reported on the books of the subsidiary need to be identified and are to be excluded in the plan's calculation of TNE. Remember to exclude from TNE only the percentage of the total intangible assets that is equivalent to the plan's ownership percentage of the subsidiary. [See Statutory Compliance for TNE]
10. Perform a limited review of Intercompany transactions between subsidiary and plan, since the equity of a subsidiary is included in the equity of a plan. For instance, a receivable from a subsidiary will not be excluded from the calculation of TNE pursuant to Rule 1300.76, because the Subsidiary's recognition of this payable to the plan is a reduction to the equity of the subsidiary, and it is, in effect, deducted from the plan's equity.
11. Review intercompany transactions between a subsidiary and a third party as if the transactions are between the plan and the third party.
12. Document findings and conclusions reached.

INTEREST RECEIVABLE

OBJECTIVES:

- A. The receivables exist and are authentic obligations owed to the plan.
- B. The plan is properly accruing interest receivable. [Refer to APB-21]
- C. Interest income is properly computed and collected in a timely manner in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.
- D. Information related to interest receivable is adequately disclosed.

PROCEDURES:

- 1. Obtain a plan prepared schedule of interest receivable that itemizes transactions comprising the financial statement balance.
- 2. Test random sample of interest receivable amounts from the schedule to determine reasonableness and accuracy of the calculations.
- 3. Trace to third party supporting documentation and/or subsequent receipt.
- 4. If interest receivable is due from an affiliated entity, then perform the following:
 - a. Review supporting agreements (i.e., Administrative Service Agreements).
 - b. Calculate accuracy of receivable based on agreement.
 - c. Determine ability to collect the interest (i.e., subsequent receipt).
 - d. Determine treatment in calculating TNE compliance (See Statutory Compliance).

PREMIUMS RECEIVABLE

OBJECTIVES:

- A. Premium receivables exist and are authentic obligations owed to the plan.
- B. An adequate allowance is provided for potential losses on premium receivables that are not collectible.
- C. Premiums receivable are owned by the plan. For example, the subscriber contracts are between the subscriber and an affiliate, instead of between the subscriber and the plan.
- D. Proper disclosure is made of any pledged, discounted or assigned receivables.
- E. Adjustments are made for retro-activity related to enrollment additions and terminations.
- F. Reconciliations are performed timely between invoices and actual collections.
- G. Anticipated premium and stop-loss insurance recoveries are adequate to cover health care costs and other costs over the contract term for a group of existing contracts. If not, then determine that proper accounting for Loss Contracts has occurred. [Refer to FASB-5]
- H. Premium receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions. [Refer to FASB-5, 105, 107, 133; SAS-1, 57, and 67]

PROCEDURES:

- 1. Complete the Premiums Checklist by interviewing appropriate plan personnel to determine the plan's revenue cycles for premiums. Include flowchart or other descriptive documents, if determined necessary. The checklist includes the following:
 - a. What types of premium revenue does the plan collect?
 - b. Billing procedures: who does the billing, when are subscribers billed (e.g. bills are prepared and mailed on xx of the month prior to the month of coverage), forms used, records maintained by plan (including subsidiary records of groups and individuals) and how is the billing recorded in the G/L.
 - c. Premium receipt procedures: how cash is posted, when received, and receipt records maintained.
 - d. How differences between amounts billed and actual amounts received are reconciled and adjustments posted.

- e. How eligibility is updated.
 - f. How often and to what bank account is cash deposited?
 - g. Method for resolving unpaid premiums to include: a) when coverage terminates; and, b) who authorizes "write-offs".
 - h. Method of determining premium receivable.
 - i. Method for determining deferred income.
2. Obtain an understanding of the Premium Receivable accounts, by line of business if applicable. Obtain understanding of plan's methodology in estimating an allowance for uncollectible receivables. Obtain understanding of plan's methodology for determining if an accrual is necessary for Loss Contracts.
 3. Review the general ledger for unusual journal entries. Request supporting documentation for those journal entries considered material.
 4. Evaluate internal controls, review the Management Letter and make any necessary changes to the examination program.
 5. Determine if further procedures are required and if so, then determine the most feasible method for verifying the receivable balance. Suggested method is as follows:
 - a. Obtain the plan's subsidiary schedule of premiums receivable with aging (hard copy or electronic file), by subscriber group, as of the examination date.
 - b. Identify credit balances that may distort the receivable balance. Discuss with plan personnel as to reason for credit balances (i.e., retro-activity for adds/deletes in enrollment; or failure to correctly capture deferred revenue); determine research and corrective action taken by plan. Reclassify such balances as a liability (i.e. deferred premium), if appropriate.
 - c. Determine whether any amounts shown as a receivable as of the examination date, which are for months of service subsequent to the examination date should be offset by an entry to deferred premium revenue. [See deferred premium revenue examination procedures]
 - d. If manageable, utilize the plan schedule as your work paper. Add columns to the schedule for tracing a stratified sample to subsequent receipts for: date and amount collected, any difference between amount of receivable and amount collected, outstanding balance, aging and comments.

- e. If the plan schedule is voluminous, prepare a schedule of the stratified sample of receivables to be reviewed.
 - Obtain a list of subscribers groups terminated since the examination date.
6. Prepare spreadsheet for review of receivables from groups with **large balances**:
 - a. Select groups that have large balances and include balances over 90 days delinquent at the examination date.
 - b. The total balance of the groups selected should be 80% of the premium receivable balance. If those balances over 90 days do not total 80% of the total receivable, then add those receivables that are over 60 days delinquent at the examination date.
 - c. Work paper column headings should include, but not be limited to, the following:
 - Subscriber group number
 - Name of subscriber group
 - Receivable balance at the examination date. Indicate the source of this information.
 - Subsequent receipts for coverage prior to examination date. Indicate the source of this information.
 - Variances: the differences between G/L premium receivable balance for each group, and the subsequent receipts may be due to:
 - Adjustments to premium revenue for retro-additions or terminations. They are amounts that should have neither been billed nor included in the receivable.
 - Amounts that are at least 60 days delinquent at the examination date. They should be considered in determination of the Allowance for Uncollectible Receivables, if not collected at the fieldwork date.
 - If the plan has not received premium subsequent to the examination date, then record the premium receivable balance at the examination date in the "Exam Balance" column and also in the "Allowance" column of your schedule.
 - Adjustments to write-off the variances, if appropriate.
 - Exam balance: this is the plan's receivable balance, less any portion of the variance to be adjusted.
 - Allowance: Set up an allowance for that portion of the examination balance determined to not be collectible. (See Allowance for Uncollectible Receivables)
 - d. Total each column.
 - e. Cross-foot the total of the premium received and the total variance. It should agree with the total of group receivables per schedule.

- f. Demonstrate on the work paper that 80% of the plan's premium receivable balance was reviewed and state the method of selecting the sample. If less than 80% of premium receivable balance was reviewed, then provide an explanation.
 - g. Make any adjusting journal entries, as appropriate.
- 7. Prepare spreadsheet for review of receivables from groups with **small balances**:
 - a. Select groups by random sample (e.g. every 10th account).
 - b. See procedure 6 (c) above and prepare work paper as for large balances. However, the calculated adjustments and allowance for uncollectible receivables is to be extrapolated to the total population of small balances. [That is, if review of subsequent receipts for twenty percent of the dollar value of small balances, then multiply the resulting adjustment and any required allowance by five.]
 - c. Select a sub-sample from the accounts reviewed and verify the rates billed to the rates indicated in the subscriber contracts. The rates billed are obtained from the billing statements.
 - d. Review selected sample of subscriber contracts for:
 - Any unusual contract arrangements, including premium waivers, refunds, discounts or baits of similar nature. [Refer to Section 1395 (a)]
 - Compliance with coverage contract changes [Refer to Sections 1374.20 to 1374.29]
 - e. Determine if plan records premium receivable from affiliates and determine treatment in calculating TNE compliance (See Statutory Compliance).
 - f. Determine if confirmations should be sent to verify balances. Document confirmation results and conclusions reached.
- 8. If plan delegates this function to an affiliate or external party, then perform the following:
 - a. Obtain and review executed contracts.
 - b. Determine the services performed on behalf of the plan and level of discretion allowed by plan.
 - c. Determine the guidelines/parameters set-forth by the plan and compliance by the affiliate or external party.
 - d. Determine how the plan monitors performance and compliance with these contracts.

ALTERNATIVE FUNDING ARRANGEMENTS FOR PREMIUM RECEIVABLES

OBJECTIVES:

- A. Receivables exist, are for valid transactions, and include all authentic obligations of third parties to the entity.
- B. Invoices are prepared in accordance with contracts and adjustments are made for retro-activity related to enrollment changes.
- C. Reconciliations are performed timely between invoices and actual collections.
- D. Uncollectible accounts are promptly identified and an adequate allowance for uncollectible accounts is maintained.
- E. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions. [Refer to FASB-5, 105, 107, 133; SAS-1, 57, and 67]
- F. Contractual arrangements for funding of premiums comply with Knox-Keene Act and Rules. [Section 1345, 1362, 1365, 1367.2, 1367.3, 1367.5 to 1367.7, 1367.8, 1373, 1373.1, 1373.2, 1373.4 to 1373.6, 1374, 1374.10, 1375.1; Rule 1300.45, 1300.67.4, 1300.68(b), 1300.75.1]
- G. Contractual arrangements for funding of premiums are operating in accordance with policies and procedures filed with and approved by the Department.

PROCEDURES:

- 1. Discuss with appropriate plan staff and obtain an understanding of the alternative funding arrangements for Premium Receivable accounts, by line of business if applicable. Prepare a separate narrative, or include in the premiums receivable narrative, to include the following topics:
 - a. Plan's method of collecting premiums/receipts (e.g. Access to employer bank accounts).
 - b. Remittance of premiums.
 - c. Arrangements with affiliates, to include any administrative services regarding these alternative funding operations.
 - d. Journal entries used in recording alternative funding transactions, including disposition of deficit or surplus.

- e. Key staff responsible for oversight of alternative funding arrangements.
 - f. Procedures for performing premium reconciliations, including when, where and by whom.
 - g. Location of group files, reconciliation, contracts.
2. Obtain supporting documents such as:
- a. Flowchart of process if needed to understand operations.
 - b. Copies of alternative funding riders to the group subscriber contracts.
 - c. Summary of operational procedures as filed and approved by the Department.
 - d. Administrative agreements regarding alternative funding arrangements.
3. In addition to applying appropriate procedures presented for Premiums Receivable, perform the following procedures:
- a. Obtain aged trial balance and test mathematical accuracy and the aging categories.
 - b. Reconcile total balance to the general ledger control account balance.
 - c. Note and investigate any unusual entries.
 - d. Determine if total credit balances are properly recorded in general ledger or require reclassification entry, if material.
4. Request listing of all alternative funding groups. Select sample of accounts to review and trace from aged trial balance to files and vice versa. For account review, perform the following:
- a. Review account file, subscriber contract, alternative funding riders, billings, subsidiary ledgers for selected accounts.
 - Determine whether contracts and riders are properly executed.
 - Determine whether reconciliation is current.
 - b. Review current premium reconciliation that compares contracted premium budget to actual medical and administrative expense for selected accounts. Determine if reconciliation and disposition of surplus or deficit is performed in accordance with administrative agreements, riders, and procedures filed with and approved by DMHC.

- c. Review disposition of deficit or surplus. Review cancelled checks and trace to source documents and to general ledger entries recorded for disposition of surplus or deficit.

POINT OF SERVICE (“POS”) BALANCE SHEET ACCOUNTS

The Examiner’s review of the balance sheet accounts for POS Operations should be coordinated with the procedures required for review of Premiums Receivable and Claims/IBNR Liabilities, as well as POS Statutory Compliance (if the POS arrangement falls under Article 5.6 of the Knox-Keene Act) to reduce any duplication of work.

OBJECTIVES:

- A. To gain an understanding of POS operations.
- B. To determine the reasonableness of POS related account balances (i.e., premium receivable, provider and claim payables).
- C. To determine that POS) related operations are in compliance with the requirements of Article 5.6 of the Knox-Keene Act. [See POS Statutory Compliance]
- D. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Obtain and review any narrative and other documentation provided by the plan. Interview appropriate plan personnel to gain an understanding of the POS products sold by the plan.
- 2. Review sample of contractual arrangements with subscribers and providers.
- 3. Review procedures for billing and collecting premiums and how recorded to the general ledger.
- 4. Prepare a narrative describing the plan’s POS operations and place with Premium Receivable work papers series.
- 5. Determine the reasonableness of the POS balance sheet account balances for receivables and for claims payable and IBNR. [Refer to Claims Payable and IBNR liability procedures]
- 6. Determine compliance with statutory compliance requirements for processing and payment of claims. [Refer to Statutory Compliance for Claims] Include a sample of POS claims out-of-network claims in all claims review work performed. Identify (e.g. with tick-marks) those claims that are related to POS out-of-network services. Review the claims in the same manner as non-POS and POS in-network claims.

FEE-FOR-SERVICE RECEIVABLE

OBJECTIVES:

- A. Fee-for-service receivables exist and are authentic obligations owed to the plan.
- B. An adequate allowance is provided for potential losses on the receivables that are not collectible.
- C. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

BACKGROUND:

A fee-for-service receivable is commonly seen on the balance sheet of a staff-model plan. It reflects moneys owed by non-enrollee patients, or for non-covered services for enrollees, following receipt of services from employee-providers of the plan. Commonly these patients will have insurance coverage. Therefore, the receivable is usually from an insurance carrier rather than the patient.

For example, a non-enrollee walks into the staff-model plan's dental office and receives dental services. The services will be provided at the usual and customary rate. The non-enrollee will be liable for the costs of that service, or if he/she has insurance, the insurance company will be liable for the costs.

This is a high-risk account because it consists of a high volume of small amounts and requires detailed audit work. Because the plan bills at UCR and most insurance companies pay only a percentage of UCR, it is common to find that the balance is overstated.

In addition, the collection process is arduous and difficult for the plan because the balance in the account is composed of many small amounts. The result is that grossly delinquent patient/insurance carrier receivables are common.

PROCEDURES:

- 1. Obtain an understanding of the Fee-for-Service Receivable accounts. Obtain understanding of plan's methodology in estimating an allowance for uncollectible receivables.
- 2. Review the general ledger for unusual journal entries. Request supporting documentation for those journal entries considered material.
- 3. Evaluate internal controls, review the Management Letter and make any necessary changes to the audit program.
- 4. Interview plan personnel to determine the following:

- a. The transactions that are recorded in the account.
 - b. The plan's credit policy.
 - c. Identification of the employee who grants credit.
 - d. Identification of the employee who posts entries to the account.
 - e. Identification of the employee who sends billings out.
 - f. Identification of the employee who collects cash.
 - g. Where receivable balances are tracked. Are they tracked in the individual field offices or at the administrative office?
 - h. Identification of the write-off policy.
 - i. Identification of when the individual receivable balance is turned over to a collection agency.
5. Consider contacting the plan's outside auditors, to discuss their methods of testing the account. A review of their work papers can be helpful.
 6. Refer to detailed procedures for Premium Receivable and perform as determined appropriate for this account. The most common procedure for verifying a receivable balance is "review of subsequent receipts", but this may not be the most effective method due to time lag between the date of service, date of billing and date of payment.
 7. The audit procedures will differ at each plan. The following is an example of procedures that relate to a dental plan with several dental offices with a high volume of individual accounts. The dental offices provide general, specialty and orthodontic services.
 - a. Reconcile the general ledger balance to the subsidiary schedules.
 - b. Verify that the subsidiary schedules agree with the aging report.
 - c. Select sample of office(s) for testing detail subsidiary records. Select sample of individual accounts from the subsidiary records. Document the individual accounts selected.
 - d. Verify that the subsidiary schedules, showing individual patient payment records are correct. These will be relied upon when performing other procedures.

- e. Review payments made prior to and subsequent to the examination date. This will indicate a pattern of payment or non-payment. If payments were made both before and after the examination date the entire balance is assumed to be collectible. If payments were made before but not after the examination date the balance may be determined to be uncollectible. If payments were made after the examination date the balance is assumed to be collectable.
 - f. Payments listed (per above paragraph) should be traced to supporting documentation.
 - g. The uncollectible amount should be projected based on sample size and percentage of the total population tested.
8. Similar procedures should be performed separately for receivable relating to orthodontics. Orthodontics usually result in larger balances that are paid over a 1 or 2 year period, and may have a separate financing/payment contract arrangements. Additionally, this receivable may have a separate allowance account.

AFFILIATE RECEIVABLES/PAYABLES (DUE TO/DUE FROM ACCOUNTS)

The Examiner's review of the balance sheet accounts for Affiliate Receivables or Affiliate due to/due from should be coordinated with the procedures required under Statutory Compliance to reduce any duplication of work.

OBJECTIVES:

- A. Affiliate receivables exist, are owned by the plan, are properly valued and appropriately reserved for uncollectible accounts.
- B. Affiliate payables exist and are properly accrued at the examination date.
- C. All material intercompany transactions are classified and valued in accordance with GAAP and reported with full disclosure in accordance with the DMHC Financial Report Form Instructions. [Refer to FASB-57 and 94; ARB-51; SAS No. 45; APB Opinion NO. 16 and 18; FASB Interpretation No. 35 and 39]

PROCEDURES:

For material transactions with affiliates or related parties, the examiner should perform the following examination procedures to the extent necessary to obtain satisfaction as to the purpose, nature and extent of these transactions and their presentation in the financial statements.

- 1. Obtain an organization chart which identifies all of the plan's affiliates and gain an understanding of the relationship between the plan and each of these affiliates (e.g. common ownership, shared management, provider, contractor, etc.) from the detailed information provided by the plan in response to our initial notification letter and opening conference. Discuss with appropriate plan personnel.
- 2. Obtain and review administrative service agreements.
 - a. Prepare a summary of services; the oversight performed by plan and compensation arrangements.
 - b. Determine if a "Right of Setoff" is contained in the agreement to support any offset between receivable and payables between the plan and affiliate.
 - c. Determine if there are any tax-sharing arrangements, pledging or guarantees.
- 3. Complete Affiliate and Inter-company Transaction Checklist to document an understanding of the types of transactions and business purpose of the transactions recorded.

4. Examine invoices, executed copies of agreements, contracts, and other pertinent documents related to the transactions on a test basis.
5. Determine that transactions agree with those described in the related agreements/documents. Compare the documents with those on file with the Department.
6. Determine that the appropriate level of management or the Board of Directors approves the transactions.
7. Obtain and review evidence for “secured receivables” for any changes in status of the recorded title, equity or security previously filed with the Department. [See Statutory Compliance for TNE and Examination Procedures for Notes Receivables]
8. Determine the Plan’s methodology for aging and collecting these receivables.
9. Determine if further procedures are required and if so, then determine the most feasible method for verifying the balance. Suggested method is as follows:
 - a. Select a number of representative intercompany income/expense transactions during the examination period and trace to supporting documentation.
 - b. Select a number of intercompany transfers of cash or other assets during the examination period and trace to supporting documentation to determine that accountability for these assets is not changed in the transfer process.
 - c. Perform tests of intercompany balances and aging of both receivables and payables, as appropriate. Verify receivable by tracing to subsequent receipts
10. For material transactions with affiliates/related parties:
 - a. Compare material transactions to the related balances of the affiliate's financial statement, when possible; or to the general ledger.
 - b. Obtain information on the financial capabilities of the other parties that would bear upon the substance of the agreements and the parties' ability to meet obligations.
11. When the above procedures do not provide evidential matter to understand a particular transaction, consider the need for application of other extended procedures.
12. If the plan is offsetting liabilities against receivables on the DMHC Financial Report Form:
 - a. Determine that such transactions are supported by a "right of setoff" document or similar language within an administrative service agreement. [Refer to FASB Technical Bulletin No. 88-2, superseded by FASB Interpretation No. 39.]

- b. Determine that only those classifications of receivables and payables, as described in the agreement, are offset. Any receivable that is non-current, or not in the normal course of business, is to be deducted from TNE. "Normal course of business" would typically include routine sales of goods or services for which collection is made in full within 30-60 days from the date the receivable was incurred. [See Statutory Compliance for TNE]

[Note: The DMHC requires a plan to execute a written “right of setoff: to clarify and strengthen the legal right of the parties.]

- 13. Determine that receivables are properly presented on the DMHC Financial Report Form and that proper disclosure is made in the footnotes, as required by GAAP. [Refer to Section 1345(s)] [Refer to instructions to DMHC Financial Report Form]
- 14. Determine if the Administrative Service Agreements indicate that the affiliate is acting as a solicitor and if it handles funds on behalf of the Plan. [See Statutory Compliance for Contracts/Solicitors]

OTHER RECEIVABLES

OBJECTIVES:

- A. The receivables exist, are owned by the plan, are properly valued and appropriately reserved for uncollectible accounts.
- B. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

When the examiner encounters a receivable balance that represents funds owed to the plan resulting from a transaction with which the examiner is unfamiliar, some basic procedures will ensure that the examiner, at a minimum, identifies a material misstatement of assets.

- 1. Interview plan personnel and obtain understanding of the account and methodology for aging and determining related allowance for uncollectible accounts.
- 2. Document understanding of the business purpose and types of transactions recorded in this account.
- 3. Obtain or prepare an aged subsidiary schedule that ties to the balance sheet.
- 4. Review support for a sample of transactions within the account. In the case of receivables from government agencies this may include a review of correspondence and cost reports filed by the plan with the agency, and any related correspondence from that agency.
- 5. Review subsequent receipt of funds for a sample of transactions. Determine ability to collect and review any allowance set up for reasonableness.
- 6. Consider sending a confirmation.
- 7. Grants receivable: Government grants (i.e., 3300 grants from CMS) are not common. In the event a plan has a government grant the following procedures in addition to the above are to be performed:
 - a. Determine how grant is recorded.
 - b. Obtain and review copy of grant documents.

REINSURANCE RECEIVABLES

OBJECTIVES:

- A. The reinsurance receivables exist, are owned by the plan, are properly valued and are collectible or appropriately reserved.
- B. The plan is calculating and recording the proper amount of the reinsurance receivables according to the terms and conditions of the insurance policy.
- C. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Obtain a copy of the plan's reinsurance policy. Review the policy for the following items:
 - a. Coverage limit - Typically, the policy will have a deductible and then will pay a percentage of claims in excess of the deductible.
 - b. Policy terms - Determine when the deductible starts; review provisions regarding the treatment of claims incurred just prior or subsequent to the renewal date.
 - c. Any requirements relating to filing deadlines for claims.
 - d. Name of insurer.
- 2. Verify that premiums are current and that the policy is in force.
- 3. Obtain a schedule from the plan which details, by specific enrollee, the reinsurance receivable accrued as of the examination date.
- 4. For a random selection of individual enrollees on this schedule, obtain the supporting documents of the specific claims incurred for that individual and the detail of how the plan calculated the receivable amount. Test the schedule in the following manner:
 - a. Review the actual claims that support the material amounts on the schedules. Verify that the amounts and dates of service are correctly reflected in the schedule.
 - b. Verify that the claims are reflected in the appropriate deductible years.
 - c. Verify that the correct deductible is used and that the reimbursement is calculated in accordance with the contract/policy.

- d. Review for receipt of reimbursement subsequent to examination date. If payment was received, then compare the amount received to the amount recorded as a receivable. Investigate the difference. Make any necessary adjustment to the receivable amount
 - e. Determine if the claim was filed with the reinsurance company. Review remittances and correspondence from the reinsurance company that may indicate that certain claims have been denied or adjusted.
 - f. Verify that provider claims that support the calculation of the reinsurance receivable have either been paid or recorded as claims payable as of examination date.
- 5. Determine the aging of the reinsurance receivables and consider whether an adequate reserve for uncollectible accounts has been set up.
 - 6. If necessary, confirm the receivable amount with the reinsurance company.
 - 7. Perform any additional procedures as determined to be appropriate.
 - 8. If the reinsurance company is "offshore", the plan must demonstrate that the reinsurance company is financially viable.
 - 9. Determine whether the insurance company is an affiliate; and if so, determine whether this receivable balance should be deducted from TNE. [See Statutory Compliance for TNE]
 - 10. Determine that reinsurance premiums are reported as a health care cost. Determine that reinsurance recoveries are reported as reduction of related health care costs. [Refer to AICPA Audit and Accounting Guide for Health Care Organizations]

MEDI-CAL REINSURANCE RECEIVABLE

OBJECTIVES:

- A. Medi-Cal reinsurance receivable exists, is owned by the plan, properly valued and is collectible or appropriately reserved.
- B. Plan is calculating and disclosing the proper amount of the reinsurance receivable according to the terms and conditions of the contract with Department of Health Services (“DHS”).
- C. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Review DHS contract and interview appropriate plan personnel to obtain understanding of Medi-Cal reinsurance.
- 2. Obtain a schedule from the plan that details, by specific enrollee, the Medi-Cal reinsurance receivable accrued as of the examination date.
- 3. For a random selection of individual enrollees listed on the Medi-Cal reinsurance receivable schedule, obtain the supporting documents of the specific claims incurred for that individual and the detail of how the plan calculated the receivable amount. Test the schedule in the following manner:
 - a. Review the actual claims that support the material amounts on the schedule. Verify that the amounts and dates of service are correctly reflected in the schedule.
 - b. Verify that the claims are reflected in the appropriate contract year. (For the purposes of 25K claims, DHS uses a fiscal year end of June 30th. A \$25,000 deductible is applied for each fiscal year.)
 - c. Verify that the correct deductible is used and that the reimbursement is calculated in accordance with the contract.
 - d. Review for receipt of reimbursement subsequent to examination date. If payment was received, then compare the amount received to the amount recorded as a receivable. Investigate the difference. Make any necessary adjustment to the receivable amount.
 - e. Determine if the claim was filed with DHS. Review remittances and correspondence from DHS that may indicate that certain claims have been denied or adjusted.

- f. Verify that provider claims that support the calculation of the Medi-Cal reinsurance receivable have either been paid or recorded as claims payable as of examination date.
- 4. Determine the aging of the Medi-Cal reinsurance receivables and consider whether an adequate reserve for uncollectible accounts has been set up.
- 5. If necessary, confirm the receivable amount with DHS.
- 6. Perform any additional procedures as determined to be appropriate.

MEDI-CAL CAPITATION RECEIVABLE

OBJECTIVES:

- A. The Medi-Cal capitation receivable exists, is owned by the plan and is collectible or appropriately reserved.
- B. The capitation receivable is calculated according to the terms and conditions of the contract with DHS.
- C. Receivables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Review DHS contract and interview appropriate plan personnel to obtain understanding of Medi-Cal capitation (i.e. premium).
- 2. Obtain copies of the capitation summaries that are received from DHS for the 2 months subsequent to and the 1-month prior to the examination date. (Normally, it takes DHS 2 months to adjust the plan's capitation for any new enrollment or terminations. If subsequent capitation summaries are not available, then obtain the plan's estimate of the supplemental capitation and review their methodology.)
- 3. Review capitation receivable amount for reasonableness. (With the exception of supplemental adjustments, DHS normally pays all capitation owed for a particular month of service within the month of service. For this reason, capitation receivable as of the examination date should normally only reflect adjustments for enrollment and supplemental adjustments.)
- 4. Review the capitation summary as of the examination sheet date and verify that the capitation for that month was received for that month through review of cash receipts as of the examination date.
- 5. Review the capitation summaries to determine if there have been any adjustments to the capitation other than the supplemental capitation. Determine that these adjustments are properly reflected as of the examination date.
- 6. Review the contract with DHS for compensation arrangements, financial requirements and any possible "paybacks" that may result in a liability to the plan.
- 7. Determine the aging of the Medi-Cal capitation receivable and consider whether an adequate reserve for uncollectible accounts is needed

8. If necessary, confirm the receivable amount with DHS.
9. Perform any additional procedures as determined to be appropriate.

MEDICARE RISK RECEIVABLE/PAYABLE

OBJECTIVES:

- A. The Medicare Risk receivable exists, is owned by the plan and is collectible or appropriately reserved.
- B. The plan is calculating and disclosing the proper amount of the capitation receivable according to the terms and conditions of the contract with Center for Medicare and Medicaid Services ("CMS").
- C. Receivables/payables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Review CMS contract and interview appropriate plan personnel to obtain understanding of Medi-Cal risk receivable/payable.
- 2. Obtain copies of the capitation summaries that are received from CMS for the 2 months subsequent to and the 1-month preceding the examination date. (Normally, it takes CMS 2 months to adjust the plan's capitation for any new enrollment or terminations. If subsequent capitation summaries are not available, then obtain the plan's estimate of the supplemental capitation and review their methodology.)
- 3. Review capitation receivable amount for reasonableness. (With the exception of supplemental adjustments, CMS normally pays the plan all capitation owed for a particular month, prior to or within the month of service. For this reason, capitation receivable as of the examination should normally only represent those supplemental adjustments.)
- 4. Review the capitation summary as of the examination date and verify through review of cash receipts that the capitation for that month was received as of the examination date.
- 5. Review the capitation summaries to determine if there have been any adjustments to the capitation, other than the supplemental capitation. Determine that these adjustments are properly reflected as of the examination date.
- 6. Determine whether a liability exists for adjustments to capitation rates for prior year and whether the liability is correctly reported on the DMHC Financial Report Form.
- 7. Determine the aging of the Medicare risk receivable and consider whether an adequate reserve for uncollectible accounts has been set up
- 8. If necessary, confirm the receivable amount with CMS.

9. Perform any additional procedures as determined to be appropriate.

RECEIVABLES/PAYABLES RESULTING FROM RISK SHARING ARRANGEMENTS BETWEEN THE PLAN AND RISK-BEARING ORGANIZATIONS (INCLUDES RISK POOLS)

OBJECTIVES:

- A. Risk Sharing Receivable exists, is owned by the plan, is properly valued and is collectible or appropriately reserved.
- B. Risk Sharing Receivable/Payable was calculated in accordance with the terms of the provider contract and payouts are supported by appropriate authorization.
- C. Risk Sharing Payable exists and is accrued within proper time period as of the examination date.
- D. Risk Sharing Receivable and/or Payable are properly reported as short term or long term on the DMHC Financial Report Form.
- E. Receivables/payables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

1. Review risk bearing organization/provider contract and narrative description of risk arrangements provided by plan. [See Statutory Compliance for Contracts/Risk-bearing Organizations.] Such narrative should include an example of settlements when a surplus occurs and when a deficit occurs; as well as any netting of several risk arrangements. Discuss with appropriate plan personnel to obtain understanding of the arrangements and recording to the general ledger. Determine if arrangements include withholds and how they are considered in these risk arrangements. Also, determine if the plan offers reinsurance/stop-loss or enrollment guarantees that may impact the calculation of these risk arrangements. Prepare a summary of understanding.

Receivables result from downside risk (or deficit) when utilization is higher than projected withholds and/or a plan processes claims on-behalf of a risk bearing organization and total claims paid is more than withholds. Payables result from upside risk (surplus) when utilization is lower than projected withholds and claims paid is less than withholds.

2. Obtain copy of plan's subsidiary schedule for the receivable/payable balance. Select a sample and perform the following:

- a. Obtain supporting schedules to support plan's detailed calculation resulting in receivable/payable balance and determine if the method of calculation is consistent with the risk bearing organization/provider contract.
 - b. Trace to supporting documentation. This may require tracing to specific claim payments and/or capitation payments.
 - c. Verify receivables through review of subsequent receipts.
 - d. Verify payables through review of subsequent disbursement.
 - e. Compare receivable/payable balances to reports required to be prepared by the plan on a monthly, quarterly and annual basis [See Statutory Compliance for Contracts/Risk Bearing Organizations].
3. Determine if the receivable is collectible. This procedure may require the review of a risk bearing organization's financial viability—review of current financial statement or other similar documentation.
4. Determine whether the plan is meeting its own contractual responsibilities, as described in the risk bearing organization/provider contract. [See Statutory Compliance for Contracts/Risk Bearing Organizations].
5. Review for current provider disputes, pending litigation and any special settlements for renewal of contracts (i.e., loaning funds, prepayment of claims). Determine the impact on the resulting receivable/payable.
6. Consider sending positive confirmations.
7. Verify that the receivable/payable is correctly reported on the DMHC Financial From as either short-term or long-term. A risk receivable may be considered long-term since the settlement date may be 180 days after the close of the risk-share organization's contract year or the contract termination date, whichever occurs first.

ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES

OBJECTIVE:

Receivables are reported at their net realizable value (i.e., total receivables less an estimated allowance for uncollectible amounts). [Refer to FASB-5]

PROCEDURES:

1. Some of the procedures will be performed through examination of the related receivable balance.
2. Obtain understanding of plan's methodology in estimating its allowance for uncollectible receivables. If the plan uses the direct write-off method, then require the plan to provide a written justification for the departure from GAAP unless determined to not be material.
3. If not obtained as part of the related receivable schedule, then obtain or prepare an analysis of the allowance for uncollectible receivables for the examination period, and perform the following:
 - a. Review accounts written off during the period and determine that they were properly authorized. Examine supporting documentation on a test basis.
 - b. Assess the reasonableness of the allowance through analysis and review of trends, as follows:
 - The relationship between premiums receivable to premium revenue. If the receivable is increasing and the revenue is constant, a collection problem may exist.
 - The relationship between the balance of the allowance for uncollectible receivables to related receivable (in total, and in relation to past due categories per aging analysis). The expectation is that a large dollar amount of "old" receivables will be offset by a large allowance.
 - The relationship between revenue, the receivable and cash receipts transactions after the examination date, including credits allowed and write-offs for unusual transactions (especially concerning past due balances and large accounts).
 - c. Review adequacy of the allowance and related provision by:
 - Review of the aged receivables as of the examination date with the plan's credit manager or other responsible individual to identify accounts of a doubtful nature and any additional allowances required.

- Review correspondence files and other relevant data to verify support of plan's representations, on a sample basis. Include past due amounts and material amounts whether past due or not.
 - Compare the total allowance determined by the Examiner based on procedures performed, as presented on the related receivable work paper spreadsheet, to the plan's Allowance account. When determining if the plan's balance is adequate, take into consideration all other relevant information you have acquired (i.e. internal controls, collection process, historical trends).
- d. If confirmations were sent, review to determine if any amounts are in dispute and impact whether the receivable is collectible or not.

NOTES RECEIVABLE

OBJECTIVES:

- A. The receivable exists and is an authentic obligation owed to the plan.
- B. The valuation and ability to collect all authentic obligations of third parties is reasonable.
- C. Determine that the plan can justify the transaction's purpose and authorization.
- D. Identify if the note receivable is from an affiliate and whether the note will affect the plan's TNE. An affiliate receivable is shown separately from normal trade receivables.
- E. Determine that the note receivable is properly reported as short term or long term on the DMHC Financial Report Form.
- F. Receivables/payables are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Interview plan personnel and obtain understanding of the account and methodology for aging and determining any related allowance for uncollectible accounts. Document this understanding in the work papers.
- 2. Obtain or prepare an analysis of notes receivable including the following information:
 - a. Maker
 - b. Date made/date due
 - c. Original terms of repayment
 - d. Collateral, if any
 - e. Interest rate
 - f. Original balance
 - g. Balance as of the examination date
- 3. Select a sample and obtain copies of promissory notes.

4. Verify any collateral/security for the notes and determine that the collateral/security is not recorded as an asset of the plan. Review the following:
 - a. For notes secured by real estate:
 - Recorded trust deeds.
 - Title insurance policies that identify the plan as the insured and in an amount at least equal to the amount of the notes for which the particular property secures (or 110% of the note amount if being secured for TNE purpose).
 - Fire insurance policies that name the plan as loss payee in an amount at least equal to the underlying note, to include any buildings or improvements that were included in the determination of the property values.
 - Evidence that requests for notice were recorded for all senior liens.
 - Appraisal for the real property prepared by a qualified and independent appraiser.
 - Board Resolution approving the note.
 - b. For collateral other than real property: board resolution, current appraisal of property, outstanding balances on all liens, and verification that the plan has an enforceable lien against the property (i.e., Uniform Commercial Code Filing with Secretary of State). [See Statutory Compliance for TNE]
5. Ascertain whether any notes are assigned, pledged or discounted by reference to Board minutes, review of agreements, confirmation with banks, etc.
6. Ascertain whether any notes receivable are owed by employees or related parties, such as officers, directors, shareholders and affiliates, and:
 - a. Obtain an understanding of the business purpose for the transactions that resulted in the note,
 - b. Ascertain that an officer of the plan or the board of directors authorized the transaction,
 - c. Determine if any notes repaid prior to the examination date were renewed,
 - d. Determine if the note is from an "affiliate". If so, then determine if the note or portion of it can be considered "secured" for purpose of determining TNE. An affiliate note receivable is usually determined to not be in the "normal course of business", because the plan is not in the business of lending funds. The amount is excluded in calculating TNE, unless the note receivable is secured by tangible collateral with equity at least equal to 110% of the receivable balance, as required by Rule 1300.76(e) and as filed with and approved by the DMHC. [See Statutory Compliance for TNE]

7. Review for collection on notes receivable subsequent to the examination date.
8. Determine the aging of the notes receivable. Determine if an adequate allowance for uncollectible notes is established. This determination is made on a case-by-case basis and should be based on all available evidence -- the amount of payments due to the plan prior to and at the examination date, but not yet received.

If the plan is making no effort to collect on a past due note receivable, it should be written-off or include an additional reserve for it in an allowance for uncollectible notes. Prior to making such adjustment discuss with management to verify your understanding.

9. Determine that interest income is computed in accordance with the promissory note and is properly, accrued, recorded and paid.
10. Consider sending positive confirmations.
11. Verify that the receivable/payable is correctly reported on the DMHC Financial Form as either short-term or long-term.

FIXED ASSETS

Fixed assets, or Property, Plant and Equipment, include land, building, furniture, fixtures, machinery, equipment and vehicles. These assets are acquired primarily for use in operations, not for sale; and, have relatively long lives. Also includes leased property and equipment.

OBJECTIVES:

- A. The assets actually exist and are owned by the plan.
- B. The valuation or basis for the assets recorded is adequately valued and conforms to GAAP and is consistently applied with respect to major categories of property.
- C. Additions to property are authentic, recorded at cost and properly distinguished from maintenance and repairs expense.
- D. The costs and related accumulated depreciation applicable to: retirements; abandonment; and, property no longer in service are properly accounted for. [For example, the plan that purchases a new computer system may also need to "write-off" the old computer system.]
- E. The estimated useful life of a depreciable asset is the period over which services are expected to be rendered by the asset. [Refer to ARB-43]
- F. Depreciation method is systematic and rational. Depreciation charged to income during the period is adequate and computed on an acceptable basis consistent with that used in the preceding year. [Refer to APB-12]
- G. All liens on property are properly disclosed in the financial statements.
- H. Fixed assets are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Prepare a lead sheet that details all the component accounts that comprise the financial statement balance.
- 2. Interview plan personnel and obtain understanding of the account and methodology for capitalization of assets, valuation of basis and related depreciation. Document this understanding in the work papers.
- 3. Obtain or prepare the following subsidiary schedules:

- a. Summary schedule of fixed assets and related depreciation (by major asset classification: property, equipment, etc.) to include the following:
 - Beginning and ending asset balance.
 - Additions.
 - Retirements and dispositions.
 - Other changes.
 - Depreciation method and life.
 - Complete depreciation schedule.
 - b. Additions at cost showing the description, date acquired, transaction reference (purchase order number, check number, vendor, etc.), estimated useful life, and cost for all additions over a materiality threshold established by examiner.
 - c. Retirements and dispositions showing the description, date of acquisition, date of retirement or disposition, cost, accumulated depreciation, net carrying value, proceeds of disposition and gain or loss on disposition.
 - d. Analysis of maintenance expense showing each transaction of a materiality amount established by examiner.
4. Trace opening balances for the summary schedules to the ending balance per the prior year's audited financial statements.
 5. Trace amounts per the summary schedule to (1) the general ledger, (2) the detailed asset records, and (3) the schedules of additions, retirements and dispositions. Re-compute the footings and cross-footings of the schedules.
 6. Perform the following on a test basis for selected additions:
 - a. Determine the addition was authorized by reference to such sources as minutes of the meetings of the Board of Directors or Financial Committee; and/or capital asset budget reviewed by the Board of Directors or Finance Committee; or by evidence of approval by appropriate, responsible personnel, in accordance with prescribed policies.
 - b. Examine such supporting documents as purchase contracts, receiving reports, vendors' invoices, paid checks, etc. for selected transactions.
 - c. Trace selected transactions to appropriate entries in the detailed property records.
 - d. Physically inspect selected (or all) major additions.
 - e. Inquire about related dispositions.

- f. Determine whether additions conform to the company's capitalization policy.
 - g. Determine that installment purchases, if any, are properly recorded.
 - h. Review purchase contracts (or contractors' billings, etc.) and identify related liabilities and determine they were properly recorded.
- 7. Perform the following on a sample of dispositions:
 - a. Determine disposition was properly authorized.
 - b. Examine supporting documents, such as bills of sale, contracts, etc.
 - c. Trace retirements to the detailed property records.
 - d. Determine that deductions from the asset accounts and related accumulated depreciation are correct.
 - e. Determine that gain or loss on disposition was correctly classified and recorded.
- 8. For fully depreciated assets, determine whether the assets are still used or retired from service. If retired and the amount is material, then determine that the asset is removed from the property, plant and equipment accounts and related accumulated depreciation accounts.
- 9. Review lease agreements for new leases and determine whether leased assets should be capitalized and that related depreciation is calculated using an appropriate method and life. Determine if interest is capitalized. [Refer to FASB-34, 62]
- 10. On a sample basis, review provisions for depreciation and/or amortization as follows:
 - a. Determine whether the methods and depreciable lives used in the current year are consistent with the preceding year and are reasonable.
 - b. Test computation of depreciation and amortization.
 - c. Ascertain that obsolete assets, if any, are properly recognized by adjustment of depreciable lives.
 - d. Trace additions to the depreciation allowance to the applicable general ledger expense accounts.
- 11. Review maintenance expense and examine supporting documentation for selected transactions to determine that amounts are properly classified.

12. Review long-lived assets for impairment and determine that plan has procedures for identifying and evaluating. (FASB-121)

PREPAID EXPENSES (INCLUDING ADVERTISING MATERIAL AND COMMISSIONS), DEFERRED CHARGES, INTANGIBLES AND OTHER ASSETS

OBJECTIVES:

- A. Prepaid expenses, deferred charges and other assets are allocated to future periods and/or realized in the ordinary course of business in accordance with GAAP.
- B. Amortization method is systematic and rational. Amortization charged to income during the period is adequate and computed on an acceptable basis consistent with that used in the preceding year.
- C. Prepaid expenses with no continuing value are removed from the books in a timely manner and/or permanent impairment of balances is recognized by write-downs charged to operations.
- D. Prepaid expenses are recorded in accordance with SOP 89-5 (Contract acquisition costs), SOP 93-7 (Advertising costs/commissions), SOP 98-1 (Accounting for the costs of computer Software developed or obtained for internal use), and SOP 98-5 (Reporting on the costs of startup activities).
- E. Any uninsured risks exist that should be considered for disclosure. [Refer to FASB 5]
- F. Intangibles, deferred charges or other assets should be deducted in the calculation of TNE for compliance pursuant to Rule 1300.76. [See Statutory Compliance for TNE]
- G. Properly reported as short term or long term on the DMHC Financial Report Form.
- H. Assets are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions. [Refer to APB-17, ARB-43]

PROCEDURES:

- 1. Obtain and review the plan's policies and procedures regarding these accounts, the methods of computing amortization, and determine any collateralization or impairment of these assets.
- 2. If account balances for prepaid expenses, deferred charges and other assets are not material to the overall financial statements, limit testing to analytical review procedures as follows:
 - a. Compare examination period ending balance per general ledger to prior-period balance and investigate any unusual variations.

- b. Review general ledger account activity and investigate any entries that appear unusual.
- 2. If account balances for prepaid expenses, deferred charges and other assets are material to the overall financial statements, obtain or prepare an analysis for each significant classification of prepaid expenses or other assets. The analysis should include adequate description of components and the following:
 - a. Balance beginning of period.
 - b. Additions.
 - c. Deductions and charges to expense and to other accounts.
 - d. Balance at the examination date.
- 3. Trace totals to the general ledger; trace beginning balance to the ending balance per audited financial statements.
- 4. Examine supporting documents for material changes during the year.
- 5. Review and re-compute amortization; determine that the amortization period is reasonable.
- 6. Determine that the carrying amount of the item does not exceed amounts properly allocable to future periods.
- 7. Trace amounts amortized during the period to the related general ledger expense accounts.
- 8. Confirm significant deposits and assets held by others, if necessary.
- 9. Obtain or prepare an analysis of prepaid insurance and insurance expenses (including life insurance premiums); perform the following additional tests:
 - a. Examine all or selected policies noting identity of insurer, descriptions and amount of coverage, premiums and period covered; compare particulars with the analysis.
 - b. Ascertain by review of the policy and the related billing advises for the insurance premiums whether the premiums are being financed and/or the policy or cash surrender value has been pledged; determine that related liabilities and finance costs have been properly recorded.

- c. Obtain confirmation of cash surrender values; consider confirmation of policies especially if premium financing is involved to determine if premium payments are current and coverage is still in force.
 - d. Re-compute amortization and trace amounts to the applicable expense accounts.
- 10. For intangible assets:
 - a. Trace authorization for major transactions to minutes of board of directors meetings.
 - b. Examine supporting documents.
 - c. Ascertain whether amortization is systematic over period estimated to be benefited, but not to exceed 40 years. (ARB-17)
 - d. Deduct from TNE calculation. [See statutory compliance for TNE]
- 11. Determine that there is no permanent impairment of value for prepaid expenses, deferred charges, etc.
- 12. Determine that balances are properly classified in the balance sheet (current vs. non-current, etc.).
- 13. Determine if any prepaid expenses, deferred charges or other prepaid assets should be excluded from TNE. [See statutory compliance for TNE]

ACCOUNTS PAYABLE AND ACCRUED LIABILITIES (OTHER THAN CLAIMS LIABILITIES)

OBJECTIVES:

- A. Accounts payable and accrued liabilities represent authorized obligations that were incurred as of the examination date.
- B. Unrecorded accounts payable or accrued expenses exist at the examination date.
- C. Accounts payable and accrued liabilities existing or incurred as of the examination date.
- D. Accounts payable and accrued liabilities are correctly reported on the DMHC Financial Report Form as short-term or long-term.
- E. All contingencies and estimated future expenses are accrued in the proper period and classified properly in accordance with GAAP.
- F. Adequate disclosure is made of any collateralized liabilities (i.e., pledged assets).
- E. Obligations are owed to employees and/or related parties.
- F. Accounts payable and accrued liabilities are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Obtain and review the plan's policies and procedures regarding the accounts payables and accrued liabilities.
- 2. Interview plan personnel and obtain understanding of the account and determine any collateralization of these liabilities and whether they are owed to employees and/or related parties. [See procedures for Affiliate Receivables/Payables]
- 3. Document this understanding in the work papers, that addresses the following:
 - a. Flow of the invoice through the various processing steps.
 - b. Physical locations of paid and unpaid invoices.
 - c. Types of subsidiary records, logs, and schedules maintained.
 - d. Frequency of payment and how prioritized.
 - e. Procedures for providing an accrual for any unrecorded invoices.

- f. Method used to determine the total liability.
- 5. Prepare or obtain the plan's subsidiary schedule that supports the examination balance.
- 6. Review supporting documentation to verify material liabilities reported by the plan.
- 7. Perform a search for unrecorded liabilities.
- 8. Consider sending confirmations.
- 9. Inquire of responsible plan staff about their knowledge of additional sources of unprocessed invoices, unrecorded commitments, or contingent liabilities.
- 10. If appropriate, confirm with the DMHC Accounting Unit to determine existence of any outstanding invoices due to the Department and trace to accounts payable to determine if recorded.
- 11. Ensure that professional and accounting fees are properly accrued based on a review of invoices and confirmations, if applicable.
- 12. If inter-company transactions are noted, it may be necessary to perform additional procedures. [See procedures for Affiliate Receivables/Payables]
- 13. Investigate any large fluctuations in accruals compared to the preceding period.
- 14. Inspect where the check stock is kept.
 - a. Look for processed/printed checks not yet released [should be stored in a vault].
 - b. Inquire as to reason and length of time for "holding" these checks.
 - c. For already issued checks, compare date of check with date check cleared the bank to confirm timeframe that Plan is "holding" checks. "Holding" checks is an indicator of a Cash Flow problem.
 - d. Perform more extensive work on the accounts payable/other liabilities.
 - e. If the plan is "holding" checks, review the treatment of these checks in the cash accounts/reconciliation and liability account. Determine if the plan adds the amount of the checks back to the cash account and back to the liability account—as though the checks were not issued—at month end.

Additional procedures are provided below for specific types of account payables:

1. ACCOUNTS PAYABLE

- a. Obtain a copy of the plan's subsidiary schedule that supports the accounts payable balance reflected in the DMHC Financial Report Form. Verify that it ties to the general ledger.
- b. If there is no subsidiary schedule or the balance does not tie to the DMHC Financial Report Form balance and the difference is material the examiner should discuss with Plan personnel and consider preparing a schedule of material items identified through a review of subsequent payments and review of vendor files.
- c. Search for unrecorded accounts payables through the review of the cash disbursement journal subsequent to the examination date. Select disbursements as follows:

Month following exam date	> \$ 500
One month later	> \$1,000
One month later	> \$2,000

Modify the amounts as appropriate for the account under review, using similar progression.

- d. Identify those disbursements that relate to service or goods received prior to the examination date and verify whether the full amount of the disbursement was recorded as of the examination date.
- e. Prepare a schedule listing the selected sample of cash disbursements and the results of the procedures performed. Suggested column headings for the schedule are:
 - Vendor #
 - Vendor name
 - Date of service
 - Amount & date of disbursement
 - Amount payable @ exam date (include only those for service or goods received prior to the examination date)
 - Amount not included in the DMHC Financial Report Form balance
 - Comments
- f. Perform an additional search for unrecorded amounts through review of unpaid invoices on hand at the date of fieldwork. Schedule material items that are not accrued by the Plan on the examiner spreadsheet (see paragraph “e” above).
- g. Review a sample of vendor folders for invoices that may include charges that are not accrued. Schedule material items that are not accrued by the Plan on the examiner spreadsheet (see paragraph “e” above).

- h. An adjustment to the account balance is required to record any resulting amount from the examiner review captured in the spreadsheet column titled: "Amount not included in plan's balance" (see paragraph "e" above).

2. PAYROLL TAX WITHHELD

- a. Compare recorded liabilities to disbursements made subsequent to the examination date.
- b. Examine the payroll tax deposit receipts and any supporting documentation.
- c. Compare liability to accrued payroll taxes for reasonableness.
- d. Trace liability to summaries of the applicable payroll registers.
- e. Prepare schedule for any unrecorded liabilities

3. ACCRUED PAYROLL TAXES

- a. Compare accruals as of the examination date to subsequent payments and determine that amounts were accrued in the proper period.
- b. Review reconciliation of payroll tax returns to the payroll registers.
- c. Prepare schedule for any unrecorded liabilities

4. ACCRUED VACATION [Refer to FASB-43]

- a. Review personnel manual and employment/union contracts to determine vacation policies.
- b. Select a sample and test plan's computation of accrued vacation payable. (This may be a detailed calculation, or an overall estimate). If you perform detail work it is advisable to begin with a review of the accrual related to management personnel, who have high salaries, high annual leave and may not be taking their vacation on a regular basis.
- c. Prepare schedules for all potential unrecorded liabilities.

**5. PENSION PAYABLE [Refer to FASB-87, 88, 132]
POSTRETIREMENT BENEFIT LIABILITY [Refer to FASB-106, 112]**

- a. Interview plan personnel to gain an understanding of pension and postretirement benefit liabilities and how they are recorded.
- b. Review supporting documents.

- c. Trace recorded liabilities to disbursements made subsequent to the examination date.
- d. Prepare schedules for all potential unrecorded liabilities.
- e. Determine that proper disclosure is made in DMHC financial report form.

COMMITMENTS AND CONTINGENT LIABILITIES

Commitments and contingencies may include losses arising from litigation, including malpractice and other claims; contingencies related to risk contracting; third-party payment and rate-setting programs; guarantees that include contractual agreements with physicians and specialists; operating leases; and loan guarantees. Loss contingencies require accrual and/or disclosure when specified recognition and disclosure criteria are met. Gain contingencies may be disclosed but are generally not recognized in the financial statements until realized. [Refer to FASB-5 and FIN-14, 34]

OBJECTIVES:

- A. Commitments and/or contingencies exist for which the underlying cause occurred at the examination date and the likelihood of an unfavorable outcome is probable and the amount or range of possible loss is estimable.
- B. Adequate disclosure and/or accrual is made for any commitments and/or contingencies incurred before and after the examination date for the time period under review.
- C. Liabilities are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Obtain and review information concerning litigation, commitments, and contingent liabilities, as follows:
 - a. Obtain a list of outstanding litigation from plan management.
 - b. Read minutes of the Board of Directors and appropriate committees for time period under examination and subsequent to the examination time period.
 - c. Read contracts, loan agreements and leases. Also, read the responses from Counsel obtained in response to Inquiry of Legal Counsel and review representation letter from plan. [Refer to examination procedures for Representation Letters]
 - d. Obtain and review information concerning guarantees from bank confirmations, if appropriate.
 - e. Request and review other documents for possible guarantees by the plan and/or affiliates, as appropriate.
- 2. Gain an understanding of the plan's policies and procedures adopted for identifying, evaluating, and accounting for litigation, claims, assessments, commitments, and contingent liabilities.

3. Examine supporting documents in the plan's and/or affiliate's possession concerning litigation, claims, assessments, commitments, and contingent liabilities, including correspondence and invoices from lawyers.
4. Review the adequacy of the liability accrual and/or disclosure in the DMHC financial report form.

CAPITATION PAYABLE

OBJECTIVES:

- A. An accrued liability for unpaid capitated medical expenses is established for authorized obligations for services rendered through the examination date.
- B. The accrued liability includes any unpaid capitation related to unassigned capitated enrollees, as well as enrollment retroactivity (additions/terminations).
- C. Capitation is paid in accordance with contract rates and terms.
- D. Capitation payable incurred is classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Request from the plan a narrative of the capitation contracting arrangements. Interview appropriate plan personnel and obtain an understanding of capitation contracting arrangements and the expense/payment system.
- 2. Determine if capitation is paid through the trade accounts payable system or the claims payment processing system.
- 3. Obtain a list of capitated providers (to include medical groups (PMG), Independent Practice Associations (IPA) and hospitals) with assigned enrollment at the examination date.
- 4. Inquire and obtain the plan's policy of requiring enrollees to select a primary care physician or dentist; how enrollment is assigned and how it is assigned if Primary Care Physician (PCP) is not selected; and paying retro capitation. Compare plan's policy with provider contracts.
- 5. Request plan to provide a list of unassigned enrollees (or enrollees who had not selected a PCP or dentist) at the exam date.
 - a. Determine if it is necessary to request list of those enrollees who are not presently assigned to a PCP or Dentist because they have requested to change their PCP or dentist.
 - b. Ensure that capitation payable contains a provision for these enrollees' capitation amounts.
 - c. Inquire as to whether the Plan assigns a fictitious provider number to unassigned enrollees.
- 6. Obtain or prepare a subsidiary schedule of the capitation payable as of the examination date.

7. Select a sample from the subsidiary schedule and the listing of capitated providers. Request provider contract for sample. Determine that capitation is paid in compliance with contract, as well as any associated risk sharing arrangements.
8. For sample selected, review capitation disbursement schedules for months subsequent to the examination date up to the date of fieldwork. Determine if any amounts paid subsequent to the examination date were included in the capitation payable amount or if an accrual is needed.
9. Review capitation payable schedule for any debit balances.
 - a. Determine if these debits are payments of capitation in advance (i.e., loans); or if they represent a receivable due to plan as a result of the plan's processing and payment of claims on behalf of a capitated provider and deducting these payments from capitation owed the provider.
 - b. Determine if provider contract addresses these arrangements.
 - c. Determine if reclassification of these debit amounts is appropriate.

DEFERRED PREMIUM REVENUE

OBJECTIVES:

- A. Deferred premium revenue is accurately computed and properly reported in the correct time period (i.e., revenue is recognized within the month of coverage and deferral of revenue is for premiums received to provide future months of service).
- B. Deferred premium revenue is classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Some of the procedures will be performed through examination of the premium receivable balance and Premium Checklist. [See Premium Receivable examination procedures]
- 2. Obtain understanding of plan's methodology in recognizing deferred premium revenue.
- 3. Obtain or prepare a deferred revenue subsidiary schedule for the examination period, and perform the following:
 - a. Determine that premium revenue reported as a receivable as of the examination date that is for month(s) of service subsequent to the examination date is reported as deferred revenue. In addition, any receipt of premium revenue within the examination date that is for month(s) of service subsequent to the examination date is reported as deferred revenue (i.e., revenue received prior to rendering services is considered deferred revenue).
 - b. Select a sample from premium receivable schedule that identifies service dates subsequent to the examination date and trace to the deferred revenue schedule. If the premium receivable schedule does not have the coverage period, then obtain this information by review of other reports such as billing report or billing statement.
 - c. Determine that previously recognized deferred revenue is properly amortized as of the examination date.
- 4. Review the general ledger for unusual journal entries. Request supporting documentation for any material journal entries.

INCOME TAXES

Accounting for income taxes is done on the asset/liability method, which is based on the valuation of current and deferred tax assets and liabilities. The amount of income tax expense recognized for a period is equal to the amount of income taxes currently payable or refundable, plus or minus the change in aggregate deferred tax assets and liabilities. [Refer to FASB-109]

OBJECTIVES:

- A. A tax liability or asset is recognized for the amount of taxes currently payable or refundable.
- B. A deferred tax asset or liability is recognized for the tax consequences of further events (temporary differences or carry forwards).
- C. Current and deferred tax assets and liabilities are based on provision of enacted tax laws.
- D. Deferred tax assets are reduced by a valuation allowance, if necessary.
- E. Income tax provisions, accruals and deferrals are classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Interview plan staff responsible for recording the income tax related transactions and gain a reasonable understanding of the purpose of the various income tax related accounts. Document this understanding in the work papers on each of the income tax related accounts.
- 2. Obtain or prepare analyses of the various current and deferred income tax assets and liabilities and related provisions showing:
 - a. Balances at the beginning of the period.
 - b. Amounts provided.
 - c. Refunds received.
 - d. Payments made, indicating date and nature.
 - e. Balances at the end of the period.
- 3. On a test basis, trace payments to cash disbursements and examine cancelled checks for evidence of timely payment.
- 4. Review significant adjusting journal entries.
- 5. On test basis, compare payments and refunds to copies of income tax returns.

6. Determine that any assessments for tax deficiencies and related interest expenses are properly recorded.
7. Schedule amounts of all temporary differences and carry forwards between income before taxes for financial reporting purposes and current income tax purposes; review and recalculate the cumulative deferred income tax provisions for the periods.
8. Determine the amount of the deferred tax asset and assess the sources of future taxable income that may be available to recognize the deductible differences and carry forwards. Based on this assessment, make a judgment call as to whether the deferred tax asset will be realized.
9. Determine if valuation allowance is adequate or needs to be set up.
10. Determine that the tax liability at the examination date is reasonable.
11. Reconcile the provision for income taxes and the tax liability.
12. Correct amounts and transfer the total exam adjustments and the exam balance to the lead sheet
13. During the "wrap-up" phase of the examination, after examination adjustments are carried to the Trial Balance, a determination needs to be reached as to whether the income tax liability will be recalculated to consider the financial impact of the examination adjustments; or, a statement will be made on the Trial Balance/Financial Report that "Not adjusted for any tax effect resulting from the examination adjustments".
14. If the plan is a subsidiary of another entity, then income taxes may be paid by the parent with a portion of those taxes allocated to the plan. Obtain a copy of any written contract for tax sharing arrangements. Review the tax allocation arrangement and determine if the transactions conform to the agreement.

CLAIMS PAYABLE AND INCURRED BUT NOT REPORTED CLAIM LIABILITY

The Examiner's review of the balance sheet accounts for claims liabilities should be coordinated with the procedures required under Statutory Compliance for Claims to reduce any duplication of work.

OBJECTIVES:

- A. The claims liability accounts, reported (claims payable) and unreported (incurred but not reported or IBNR), are recorded or accrued for the health care costs that are rendered as of the examination date.
- B. The amounts reported on the DMHC Financial Report Form as claims payable and the various accruals for IBNR reasonably reflect the actual liability in these classifications.
- C. The claims system and the data/reports generated are reliable.
- D. The plan's method of calculating the claims liability is suitable to the plan's operations and in compliance with Knox-Keene requirements. [See Statutory Compliance for Claims]
- E. The claims liability is classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

1. WALK-THROUGH OF CLAIMS PROCESSING SYSTEM

The purpose of the walk-through is to obtain an understanding of the plan's: (a) claims payment processing system and the flow of a claim through the process; (b) methodology used to record and accrue the total claims liability; (c) process for capturing claims data timely; and, (d) compliance with applicable Knox-Keene Act and Rules. The walk-through also provides an opportunity to visually observe and immediately note any abnormalities that may affect the testing of claims (i.e. claims piling up in the work area may indicate a backlog problem).

- a. Obtain from the plan and review any narrative of the health care delivery system; policy and procedures for claim processing; any overview/flowcharts of the claims payment processing system; and any claim reports. Prepare a list of questions for discussion with claim staff that result from review of documentation.
- b. Determine if claims processing, or any portion, is outsourced to an affiliate, a third-party, and/or is performed out-of-state.
 - Obtain and review written contracts.

- Determine appropriateness and feasibility of performing walk-through. If not feasible, perform alternative procedures that should include interview staff at the other entity location involved in claim processing.
 - Document the oversight procedures the plan has over the claims process that is outsourced.
 - Identify the plan management position responsible for oversight.
 - Determine procedures and obtain copies of reports used by plan management to monitor compliance with claim requirements under the Knox-Keene Act and Rules.
 - Determine that oversight includes some form of physical on-site inspection of the claim process on at least an annual basis. [See also Technical Assistance Guide for Assessment of Health Plan Management of Claims (TAG)]
- c. Using the Claims Checklist as a guide, interview claims processing personnel and perform a walk-through of the claims processing system to gain an understanding of the flow of a claim from the time it is received in the mailroom, the processing and denial/payment of the claim, through the permanent storage of the claim. The walk-through is to begin with the mailroom (or wherever the mail first arrives at the plan's facility.) The following should be determined during the walk-through:
- 1) Determine the claims processing backlog. This should be expressed in the number of days of unprocessed claims. Look for reasonableness. Estimate the elapsed time between receiving a claim to mailing the payment: identify the number of days of claims yet to be processed, plus the number of days to the next check run, plus the number of days it takes to match the check with the explanation of benefits and then mail. [Example: oldest claims are stamped received 30 days from the date of the walk-through, plus 7 days to the next check run, plus an additional 3 days to review the checks, match with EOB and mail equates to estimate of a 40 day backlog.]
 - 2) Inspect the date of receipt on claims throughout your walk-through. This will include the mailroom, file cabinets where unprocessed or pended claims are stored, on processors' desks and in their drawers, pended claims waiting for medical review, etc.
 - 3) Determine if there are claims or claims processors located at another site.
 - 4) Observe processors (not supervisors) working various types of claims. Determine if work incentives are established for processors and whether extra shifts are established or temporary employees hired—may be indicator of backlog of claims.
 - 5) Determine if the plan processes claims for other entities (e.g. medical groups, affiliates). If so, determine the following:
 - Is there an Administrative Service Agreement in place?
 - How does the plan track the claims from the other entities?
 - Are separate claim lags maintained?
 - How are payments made on non-plan claims and whose check stock is used?
 - Does processing claims on behalf of another entity create a backlog for plan claims?
 - 6) Note location and inspect claims that are pended. Also, note how claims are tracked.

- 7) Determine if claims are forwarded to outside utilization review or to re-pricing companies. Determine how claims processors and/or outside companies are compensated. [Refer to Section 1399.56].
- 8) Determine whether the claims processors are employed by the plan. If not, document the oversight procedures the plan has in place and identify the plan's key management position responsible for this oversight.
- 9) Determine whether the plan is receiving encounter forms/claims from capitated providers. How are they handled differently from claims?
- 10) Determine that written provider contracts exist, are in the name of the plan and support the provider payment rates.
- 11) Determine how non-contracting provider claims are identified. Are they forwarded to another area for processing? How are out-of-area claims paid? Are enrollees balance billed for any difference between billed and paid amount?
- 12) Determine how claims are priced. Are any claims adjudicated and/or priced manually? How often are new rates given to processors?
- 13) Determine how large dollar claims information is collected for monitoring reinsurance recovery. Who performs this function? How is it communicated to Accounting for establishing Reinsurance Receivable?
- 14) Identify the reports that are created, and whether the appropriate personnel review them. Determine if reports can be incorporated into examiner's work.
- 15) Inspect where the check stock is kept. Look for processed checks not released and note date of issuance (holding of checks).
- 16) Determine who pays the claims. Are they paid outside of the claims department? By trade accounts payable staff, accounting staff, marketing staff?
- 17) Determine whether the plan has procedures in place to pay interest on complete, uncontested claims paid late, as required by Sections 1371 and 1371.35. Does the timeframe include time delay between printing of check and mailing of check? [See Statutory Compliance for Claims]
- 18) Determine if there is an additional level of review after the claim is adjudicated for payment and if a plan employee performs this review.
- 19) Determine the plan's TERMINOLOGY, as it may not be the same as the Examiners. [For example: claim vs. authorization/referral—plan may not consider a claim resulting from an authorization or referral as a "claim" and may process them differently.]

2. INTERVIEW ACCOUNTING STAFF/ACTUARY

Interview appropriate staff in accounting or finance department of plan to gain an understanding of the methodology used to calculate, record, and accrue the liabilities for claims payable and IBNR to the general ledger/financial statements.

3. COMPLETE CLAIMS CHECKLIST

Complete the Claims Checklist after interview of appropriate claim personnel, walk-through of the claims processing system, and interview of appropriate accounting and actuary

personnel. Include any flowcharts or other descriptive documents, if determined necessary. The checklist may include the following:

- a. Number of claims received in a day or week and the claims back log.
- b. Type of claims. (Emergency in-area/out-of-area, hospital, specialty, ancillary)
- c. Claims receipting and batching procedures.
- d. Locations of claims before, during and after processing.
- e. Claims data input.
- f. Processing/adjudication/pricing procedures. Include procedures for any manual adjudication of claims.
- g. Processing – types of edits included in the system (e.g. “reasonableness” checks).
- h. Procedures for denial and/or pending of claims. Indicate whether claims are denied on admitting or discharge diagnosis code.
- i. Procedures for follow-up on pended claims.
- j. Frequency and prioritization of checks-writes.
- k. Location of printed claim checks that are not yet released for mailing.
- l. For a new claim system, describe the procedures in place to monitor the accuracy of the data produced by the new system.
- m. Descriptions of each report produced from the claim system and include a sample of each report.
- n. Description of Health Care Delivery System to include:
 - Various arrangements for the provision of medical services.
 - Withhold and other risk-sharing or risk-shifting arrangements with providers. Request a narrative description with examples, if appropriate.
 - Arrangements with an affiliate provider or hospital that results in receivables (or deposits, prepaid) that should be considered as to impact on TNE calculation. [See Statutory Compliance for TNE and Affiliates]
- o. Description of Referral/Authorization System to include:
 - When authorizations are required

- How are referrals to hospital, specialty, and out of network services handled by primary care physicians or others.
- Delegation to capitated providers.
- Length of time an authorization is valid.
- Method of matching authorizations to claims.

p. Description of Accounting for Transactions to include:

- Method of calculating the Claims Payable balance to include month-end accounting entries.
- Method of calculating the incurred but not reported liability to include month-end accounting entries.
- If the claims system is a separate system module from the general ledger, describe the process by which claims transactions are transferred to the general ledger.

4. DETERMINE ADEQUACY OF CLAIMS LIABILITY AT EXAMINATION DATE

Discuss with plan personnel and gain an understanding of the plan's method of calculating its claims liability. The plan may calculate the claims payable and claims incurred but not reported ("IBNR") liability using one of several different methods.

DMHC IBNR CALCULATION: For most full-service plans and some of the larger specialized plans that pay claims, the examiner will obtain two years of claims data in an electronic format and perform an independent calculation of the plan's total claims liability (both claims payable and IBNR) using the ACL Software program.

Objectives:

- Test IBNR Claims Lag
- Build an IBNR Lag from the Claims Data
- Perform IBNR Analysis from IBNR Model

Procedures:

- Obtain the following claims information dating back TWO years (XX-XX-XX to current date) on a CD in DBASE format. Claims data should include, at the minimum, the following fields:
 - Claim number (or an unique number to identify a claim)
 - Date of service (from and to dates)
 - Date received
 - Date paid
 - Amount billed

- Amount paid
 - Withholds
 - Date of interest paid (If interest is paid separately)
 - Interest payment check number (If interest is paid separately)
 - Provider Status (i.e. contracted or non-contracted providers, or in-network /out-of-network)
 - Claim Status (i.e. paid, pended, denied, adjusted, waiting to be processed, and etc.)
 - Service Type (i.e. Emergency, Out-of-area, In-Patient/Out-Patient, Rx and etc.)
 - Line of business
- b. Obtain the following additional information/documentations:
- File Layout, including a list of the codes used in the database.
 - The last six months (XX-XX-XX to XX-XX-XX) claims check register.
 - Enrollment by month for the last 12 months.
 - The Plan's IBNR Model.
 - How does Risk sharing or overpayment recovery factor into IBNR?
 - Any provider rate increases within last two years?
 - Inpatient days per thousand for the last 12 months.
 - Do the paid claims include capitation deduction payments or encounter claims? If yes, obtain an indicator for cap-deducted claims.
- c. Verify completeness of claims data received. Compare total amount paid based on the claims information provided by the plan to the Cash Disbursement Journal (claims check register). Request the plan to prepare a reconciliation schedule for a material variance.
- d. Create an IBNR Lag from the Claims Data based on Month of Service and Month of Payment.
- e. Prepare IBNR analysis based on IBNR Lag and perform a run-out analysis on a quarterly basis to include the last year-end.
- f. Calculate the liability at the examination date and also bring forward to the most current time period (i.e., if examination date is quarter ended December 31 and fieldwork is being performed April or May, then also calculate IBNR as of quarter ended March 31).

REVIEW OF PLAN'S IBNR CALCULATION: The following procedures may be used for health care service plans with a low volume of claim payments. These examination procedures are presented based on the most common methods of calculating the claims liability:

METHOD ONE: The plan calculates the claims liability using only one lag study. The liability calculated is the aggregate claims liability for both reported and not reported claims. [Refer to DMHC Financial Report Form #1-Part B: Liabilities and Net Worth, lines 3 to 6]

The lag study provides the **month of service** on one axis and the **month of payment** on the other axis. [Refer to Rule 1300.77.2]

Procedures:

- a. Verify the reliability of the lag data. Perform a reconciliation of the total claims paid in the "examination balance sheet month" to the Cash Disbursements Journal. There usually are reconciling items, and the examiner should review the support for those items. [Note: Cash Disbursement Journal may not include amounts withheld from provider payment. However, when calculating the IBNR claims liability, the data used must include the total claim paid amount plus withhold.]

Expand the plan's lag using their most current paid claim data to fill in as many additional cells of the lag study as possible. It is preferable to have at least three months of data following the examination date. It is advisable to perform this procedure later in the examination so that additional months of paid claim data will be available.

- b. Calculate the liability.
 - Use the plan's completion factors to calculate the claims liability, if they appear reasonable. If there is three months of paid claims data beyond the examination date, use the completion factor for Month 4 to calculate Total Claims to be Paid for the **Month of Service month that is the Balance Sheet month**. Similarly use the completion factor for Month 5 to calculate Total Claims to Be Paid for the Month of Service **prior** to the month of the examination date. Continue this for all months of service where the completion factor is less than one hundred percent.
 - Perform the calculation for all other months where the completion factor is 100% for which claims are received since the examination date.
 - Refer to the column headings of the Schedule in Rule 1300.77.2 for the remaining calculations.
 - Only calculate the **completion factors** if the plan's completion factors do not seem reasonable. To calculate the completion factor, prepare a schedule of paid claims for the historical period where all claims are paid for all months of service on the schedule.
 - The calculated number is the total claims liability. Compare it to the total on the DMHC Financial Report Form Report #1-Part B lines 2 to 6.
 - Verify that the allocation of the total liability to each of the lines 2 through 6 on the DMHC Financial Report Form is reasonable. Verify that it relates to current data for each specific classification.

METHOD TWO: The plan calculates only the accruals on one lag study. [Refer to DMHC Financial Report Form Report #1-Part B lines 3 to 6]

The liability calculated represents claims that are Incurred But Not Reported (IBNR). There will be one lag, with the **month of service** on one axis and the **month of receipt** on the other axis.

The calculation required to obtain the accrual is performed in a similar manner as in Method One above, except that information on the vertical axis is based on **month received, and not month paid**. Although the amounts recorded on the lag will be paid amounts it is scheduled by month **received**, therefore the data cannot be verified by tracing to the Cash Disbursements Journal.

Procedures:

- a. To test the data on the lag, (month received data), ensure that the claims that are recorded in each cell are for the correct paid amount and are recorded in the appropriate cell.
- b. Ask the plan to run a list of the claims for two adjoining cells. (Select cells with low volume).
- c. Verify that the total of the claims agree with the cell total, and then select some claims to review the date received and the amount paid.

[Note: These procedures may be coordinated with the procedures to review individual claims, so that the same claims are reviewed for more than one purpose.]

- d. Expand the plan's lag using their most current paid data to fill in as many additional cells of the lag study as possible, preferably at least three months of data following the examination date. It may be advisable to perform this procedure later in the examination so that additional months of paid claim data will be available.
- e. Calculate the liability.
 - Use the plan's completion factors to calculate the claims liability, if they appear reasonable. If you have three months of claims data beyond the examination date, use the completion factor for Month 4 to calculate Total Claims to be received for the Month of Service month that is for the Balance Sheet month.
 - Similarly use the completion factor for Month 5 to calculate Total Claims to Be Received for the Month of Service prior to the month of the examination date.
 - Continue this for all months of service where the completion factor is less than one hundred percent.
 - Perform the calculation for all other months where the completion factor is 100% for which claims are received since the examination date.
 - Refer to the column headings of the schedule in Rule 1300.77.2 for the remaining calculations.

- Only calculate the completion factors if the plan's completion factors do not seem reasonable. To calculate the completion factor, prepare a schedule of paid claims for the historical period where all claims are paid for all months of service on the schedule. To calculate the completion factor, prepare a schedule of paid claims for the historical period where all claims are paid for all months of service on the schedule.
- The calculated number is the total IBNR liability. Compare it to the total on the DMHC Financial Report Form Report #1-Part B lines 3 to 6.
- Verify that the allocation of the total liability to the DMHC Financial Report Form, lines 3 to 6 is reasonable. Verify that it relates to current data for the specific classifications.

METHOD THREE: The plan calculates some of the accruals using a lag, and others by accruing the estimated amount to be paid on outstanding authorizations for service.

The plan will accrue an amount that represents the number of authorizations in the system that are expected to eventually result in service being provided.

Procedures:

- a. Trace claims paid after the examination date, with date of service prior to the examination date, to the authorization list to ensure that the claim was included in the accrual at the examination date.
- b. For those accounts that are calculated using a lag study, refer to Method One or Two above, as appropriate.

METHOD FOUR: The plan's records are not presented in a manner that allows easy verification of the reasonableness of the liability.

Procedures:

- a. Ask the plan to print a listing of all the claims paid since the exam examination date for dates of service prior to the examination date (Referred to as a Claim Run-Out.).
- b. Verify the completeness of such a list by:
 - Select some large claim payments from a current Cash Disbursements Journal, and review breakdown by claim, of each payment.
 - Trace claims that were for service prior to the examination date to the Claims Run-Out to verify that the run-out includes all claims.
 - After verifying that the Run-Out is an accurate listing of claims paid, calculate the total dollar amount of these claims and compare the total with the plan's total claims liability at the examination date. It is probable that the plan's liability will be a slightly larger amount than the total of the Run-Out. For example, if the Run-Out represents claims paid in the two months since the exam balance date, than it

represents 60-70% of claims for the month of service of the exam balance sheet month, and over 90% of claims paid for months of service prior to that.

5. DETERMINATION OF CLAIMS PAYABLE

Claims payable means those claims that are on the plan premises at the examination date, that have not been adjudicated or for which the claim check has not been mailed.

The plan may calculate Claims Payable (DMHC Financial Report Form Report #1-Part-B line 2) separately from the IBNR estimate or it may include it in the IBNR calculation, as presented above. If the latter, the plan will need to support its method of determining the portion that is recorded as claims payable on DMHC Financial Report Form Report #1-Part-B line 2.

Procedures:

- a. If claims payable is included as part of the total claims liability, then gain an understanding as to how the plan determines the claims payable balance and obtain supporting documentation. (See Method One above.) Review and test the support for the calculation. Verify that the support is based on current financial data. The plan should provide a schedule of adjudicated claims waiting for payment as of the examination month end and provide a means of estimating all other claims on the plan premises that are still in the review process. Other methods used by a plan may include estimates based on an actual inventory number of claims by an amount that represents an average claim. In this example, the "average" claim should be based on current paid claims data.
- b. If the plan calculates Claims Payable separate from the IBNR calculation, as was seen in Method Two and Three above, then gain an understanding of how the plan calculates the claims payable balance. Obtain the supporting documentation. Review and test for reasonableness of the balance. If this is not possible, verify the reasonableness of the methodology used by the plan.
- c. If the plan's balance is supported by a schedule of claims payable, trace the claim payments made in the early part of the following month back to the schedule to ensure that the schedule is all-inclusive.
- d. If paid claims information was provided for several months after the examination date, perform an inquiry totaling all claims received on or prior to the examination date that were paid after the examination date.

6. REVIEW OF HISTORIC LIABILITY

Procedures:

- a. In addition to the above procedures, the examiner should also review the reasonableness of the claims liability at three and six months prior to the examination date.
- b. If the accrual is inconsistent, (for example, if the accrual swings from a material over-accrual at one quarter-end to a material under-accrual at the next quarter-end) it suggests that the plan's method of calculating the accrual is not providing a reasonable estimate, and also that the plan is not consistently reviewing the claims run-out to ascertain whether the method needs modification.
- c. If it is determined that the accrual is inconsistent, the plan should be required to file with the Department a post-period review of paid claims. For example, a filing for the quarter ended June 30, 2004 would show a run-out of claims paid during the prior six months for service date of December 31, 2003 and prior. The filing should also include a comparison of the total paid claims to the accrual recorded at December 31, 2003. The plan should attach these filings with the DMHC Financial Report Form filings, in addition to Schedule I, and should be required to continue filing them until the accrual is reasonable and consistent.

REVIEW OF INDIVIDUAL CLAIMS

Medicare claims are exempt from certain claim reimbursement and settlement practices of the Knox-Keene Act and Rules [See Statutory Compliance for Claim Reimbursement and Settlement Practices]. However, it is necessary to review a sample of Medicare claims to determine the accuracy of payment for these Medicare claims.

OBJECTIVES:

- A. Claim data is accurate.
- B. Claim reimbursements are in compliance with contractual arrangements.

PROCEDURES:

1. CLAIM TESTING APPROACHES

a. Attribute Sampling Approach

This approach in sampling and testing claims is driven by the principles of statistical analysis, and at the same time results in the most cost effective sample size based upon the characteristics of the population. Attribute sampling is used to test the characteristics of claims, such as whether they were processed and paid correctly.

b. Tailoring Approach

To tailor the sampling approach to the needs of a particular engagement, one first needs to develop an understanding of the systems used to process claims and to determine whether those systems have changed over time. Different systems or approaches to processing claims would mean that those claims populations should be separated or stratified, resulting in separate samples drawn from each stratum. Changes in claims processing would also mean that claims processed before or after the change are to be separately sampled.

The Department's initial approach incorporates the following statistical criteria that is used for the analysis of each category of claim:

- Deviation rates of 50% that may be revised during testing, when actual deviation rate is determined.
- Rate of tolerance or precision level of 5%.
- Confidence interval of 95%.

The error or deviation rate in the population is used in the sample size formula to determine the size of the sample of claims to be audited. As can be seen on the chart below, the error rate in the population determines the sample size to be used. The

maximum sample size is needed when there is a 50% probability that the claim is processed right and a 50% probability that it is processed wrong.

Example of Sample Sizes for Attributes Sampling Based on the Deviation Rate in the Claims Sample:

Deviation Rate 95% Confidence Level w/ 5% Precision Interval	Sample Size
2%	31
4%	60
6%	87
8%	114
10%	139
12%	163
14%	186
16%	207
18%	227
20%	246
22%	264
24%	281
26%	296
28%	310

- Obtain from the plan a download of specific database fields to be considered in the testing process.
- Select claims for testing.
- Obtain a copy of all the paper support for the claim or view on-line. The supporting documents will depend upon the specific claims selected for review.
- For the adjusted claims (both paid and denied), review each transaction sampled to determine:
 - Claim image and information availability (as applicable).
 - Data entry accuracy.
 - Presence of authorization, when applicable.
 - Beneficiary eligibility as of the dates of service.
 - Claim filing timeliness.
 - Claim payment/denial timeliness.
 - Accuracy of claims pricing and payment (paid claims only).
 - Accuracy of provider information on the claims system versus actual provider contracts (for a selected sample).
 - Application of required medical management procedures (as appropriate, depending on requirements).
 - Appropriateness of denial decision (denied claims only).

c. Variable Sampling Approach

Variable sampling is the appropriate method of sampling, when attempting to estimate dollars or other quantitative characteristics. There are three types of variable sampling that could be used to test health care claims:

Simple Variable Sampling - In order to select a simple variable sample, one must first examine the population (preferably using electronic data) and determine the standard deviation of the paid amounts. Assuming that the standard deviation is within an acceptable dollar range (based on the desired confidence interval and precision level), a sample size can be determined using the desired confidence interval and precision level. Sample size is directly related to the standard deviation of the billed amounts; a higher standard deviation results in a higher sample size. Using a random number generator, one would select a random sample based on the calculated sample size. The claim selected would be tested and the results could be extrapolated over the sample population. Simple variable sampling provides reliable estimates if claims do not vary greatly. Thus, if the population's standard deviation of the billed amounts is determined to be volatile, simple variable sampling must be modified to address these problems. Such modifications are described below.

Difference Sampling - Selecting a sample utilizing the difference sampling methodology is essentially the same as selecting a sample utilizing simple variable sampling. However, instead of using the standard deviation of the population in the calculation, the standard deviation of the differences/errors in the population is utilized instead. Prior to being able to utilize this approach, a pilot sample would need to be selected and tested to estimate the differences/errors in the population. Because the standard deviation of the differences in the population will always be smaller than the standard deviation of the entire population, the resulting sample size will also be smaller under difference sampling.

Stratified Variable Sampling - Stratified variable sampling is based on the same theoretical premises as simple variable sampling, but claims are stratified based on a certain population parameter before sampling. The procedure involves the segregation or separation of the claims population into subgroups or strata (layers) with similar characteristics, and then randomly selecting separate, independent samples from each stratum. For example, claims might be segregated by type (e.g., inpatient, outpatient, etc.), risk level (high, medium or low) or paid amount (e.g., paid amounts between \$0 and \$100, \$100 and \$250, etc.) Each stratum must be sampled separately and the results from the stratum may only be extrapolated on to claims that fall within each stratum's range.

Stratified sampling is often used when the paid amount varies greatly. When a universe has a high degree of variability, the sample size required to provide a reasonable degree of precision may be quite large. In this case, stratified random sampling will improve precision over the method of simple variable sampling, while also reducing the sample size. Stratification is used to increase the sampling efficiency and the effectiveness

because it may ensure representation of all the different kinds of elements.

2. SELECTION OF CLAIMS

- a. Select claims from a schedule of paid claims, such as the Cash Disbursements Journal (minimum of 30, up to 100+ for a large plan), as follows:
 - Select claims disbursements (checks) from disbursement schedule. Each disbursement (one check) may include many claims.

3. REVIEW OF CLAIMS

When reviewing a claim review the entire history related to the claim, not only the events related to the claim payment selected.

- a. Ask the plan to print out the detail of the claims included in the disbursements (checks) you have selected. The printout should include the following detail:
 - Provider name or #
 - Claims #
 - Date of Service
 - Date of Payment
 - Check #
 - \$ of claims
 - \$ allowed
 - \$ co-payment
 - \$ withhold
 - \$ paid
- b. Select the claims for review from this printout. The sample should include primary, specialty, inpatient, ancillary and emergency-in-area and out-of-area claims. Request the claim or a copy of claim, and related provider contract.
- c. Set up a spreadsheet work paper to record the performance of the following:
 - Verify claim payment timeliness with Section 1371, which states that a plan shall reimburse claims or any portion of any claim no later than 30 **working** days (if a specialized plan) or if a full service HMO (except for the non-HMO lines of business for Blue Shield) within 45 **working** days after receipt of the claims by the plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified in writing that the claim is contested or denied, within 30 **working** days (if a specialized pan) or if a full service HMO (except for the non-HMO lines of business for Blue Shield) within 45 **working** days after the receipt of

the claim by the plan. Note the number of business days between receipt of claim and payment of claim in the appropriate column of the work paper. If the number is "over 45 working days", or "over 30 working days", as described above, then review the plan documentation to ensure that the plan's handling of the related documentation is in compliance with this Section. Record findings in the "Comments" column.

- Verify compliance with Section 1379, which requires every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan. (This is also referred to as the "hold harmless clause"). Note your findings in the appropriate column, and describe any exceptions in the "Comment" column.
- Verify compliance with Rule 1300.67.8, which lists the requirements of a contract between the plan and provider. Note your findings in the appropriate column, and describe any exceptions in the "Comment" column.
- Verify that the information on the individual claims agrees with the information contained in the plan's disbursement detail.
- Complete all other columns on the work paper with information from the plan's disbursement detail.
- Verify that the amount of withhold agrees with the contractual arrangements for that provider. Note your findings in the appropriate column, and describe any exceptions in the "Comment" column.
- Verify that the amount "allowed" (i.e. contracted amount) on the claim agrees with the contractual arrangements with that provider. Note your findings in the appropriate column, and describe any exceptions in the "Comment" column.
- Verify that the amount paid on the claim agrees with the provider contract, on a test basis. Include each type of claim amongst those tested. (e.g. individual provider, specialist, IPA or medical group, hospital, ancillary, etc.)
- Compare date of check with date check cleared the bank to determine whether Plan is "holding" claim checks. If plan is "holding" checks, they may have a Cash Flow problem. Test more claims in different months, if plan appears to have a Cash Flow problem. If the plan is "holding" checks, are they adding the amount of these checks back to Cash at the end of the month and increasing Claims Payable account?
- Compare the claim's "Received Date" with the date that the Provider signed the claim. If there is more than 20 days between date of Provider's signature and Date of Receipt, perform additional procedures to determine whether the plan is date-stamping the claim with the incorrect date.

NOTES PAYABLE, LONG TERM DEBT AND DEBT EQUIVALENTS

OBJECTIVES:

- A. All notes payable, long-term debt and debt equivalents existing or incurred as of the examination date are recorded in the financial statements at the proper amount and period.
- B. Related interest expense (including discount or premium) is accounted for in accordance with GAAP.
- C. Disclosure of pledged or mortgaged assets for collateral against loans is adequately disclosed in the DMHC Financial Report Form.
- D. Any subordinated debt has been filed and approved by the DMHC. [See Statutory Compliance procedures for TNE]
- E. Notes payable, long term debt and debt equivalents are properly reported as either short-term or long-term in the DMHC Financial Report Form.
- E. Debt is classified and valued in accordance with GAAP and reported in accordance with the DMHC Financial Report Form Instructions.

PROCEDURES:

- 1. Obtain and review the plan's policies and procedures regarding these types of liabilities. Interview plan staff responsible for recording these liabilities and gain an understanding of the nature and terms of these accounts. Document this understanding in the work papers.
- 2. Obtain or prepare an analysis of notes payable, long-term debt, and capitalized lease obligations showing the following:
 - a. Description
 - Date of origin
 - Type of debt and maturity (e.g., subordinated)
 - Face amount
 - Interest rate
 - Timing and amount of payments.
 - b. Principal
 - Balance at beginning of year.
 - Additions
 - Payments

- Balance at the examination date.

c. Related Interest

- Accrued interest at beginning of year.
 - Expense incurred during examination period.
 - Amount paid during the examination period.
 - Accrued at the examination date.
3. Trace totals to the general ledger and subsidiary ledgers for notes payables, long-term debt, and capitalized lease obligations.
 4. Trace authorization for all new debt (including such debt equivalents as capitalized leases) to the minutes of the Board of Directors.
 5. Review supporting documentation for material and new debt (and debt equivalents) and related interest expense (i.e., note and loan agreements, subordination agreements, lease agreements, correspondence from legal counsel, etc.).
 6. Obtain copies of debt agreements, if needed to support an area that requires further investigation or an apparent exception.
 7. Review material lease agreements to determine that they meet capitalization requirements and whether they were capitalized at effective rates of interest in conformity with GAAP. [Refer to FASB-13, 22, 23, 27, 28, 29, 91, 98 and FIN-19, 21, 23, 24, 26, 27]
 8. Confirm outstanding balances, terms, conditions, and compliance with covenants with the credit grantor or independent trustee, as deemed appropriate.
 9. Examine cancelled or paid notes. Consider confirming large notes paid or cancelled during the year.
 10. Re-calculate interest expense and amortization of debt discount or premium on test basis and reconcile interest expense with debt outstanding for the examination period.
 11. Review subsequent payment or renewal of material liabilities through fieldwork date.
 12. Search for unrecorded liabilities through the review of the cash disbursement journal subsequent to the examination date
 13. Determine that notes payable, lease, long-term debt, and debt equivalents are properly classified as short-term or long-term on the DMHC Financial Report Form and that proper footnote disclosure is made.
 14. For subordinated debt [Also see procedures for Statutory Compliance for TNE]:

- a. Verify that the subordination agreement was approved by the DMHC.
- b. Trace to copies of the executed notes and subordination agreements filed with the DMHC.
- c. Determine that any payments and accrual/payment of interest is calculated in accordance with the note and subordination agreement.
- d. Determine if the plan has violated any terms of the note or related subordination agreements. Note any violations in the work papers.
- e. Highlight the subordinated balance that can be included as equity in the TNE calculation.
- f. Determine that subordinated liabilities and related accrued interest is properly reported on the correct line item of the DMHC Financial Report Form.

STOCKHOLDER'S EQUITY

Stockholder's equity (or Net Worth) is generally classified according to its source into the categories of:

- Capital (i.e., Common Stock, Preferred Stock or Contributed)
- Additional Paid-in-Capital (or Paid in Surplus)
- Minority interests
- Retained earnings (or Fund Balance)

[Refer to ARB-43, 46; APB-6, 12, 14 and FASB-129]

OBJECTIVES:

- A. Stockholder Equity transactions and commitments (i.e., options, warrants, rights, etc.) are properly authorized.
- B. Transactions and commitments are recorded at the proper amounts and in the proper period.
- C. Stockholder Equity is proper classified and valued in accordance with GAAP and reported with footnote disclosure in accordance with the DMHC Financial Report Form instructions.

PROCEDURES:

Obtain and review the plan's policies and procedures regarding stockholder equity transactions. Interview appropriate plan staff and gain an understanding regarding these types of transactions.

Document this understanding in the work papers.

3. Capital Stock and Additional Paid-in Capital
 - a. For each class of stock (common, preferred) identify the number of authorized shares, par or stated value, privileges and restrictions.
 - b. Obtain or prepare an analysis of the activity in the accounts. Trace opening balances to the previous annual audit report.
 - c. Review Board of Director minutes, Bylaws and Articles of Incorporation for provisions relating to capital stock and support for all changes in the accounts, including authorization from the Board minutes; stockholders meetings, and correspondence from legal counsel.
 - d. Account for all proceeds from stock issues (i.e., stock option and stock purchase plans):

- Re-calculate sales price and applicable proceeds.
 - Determine that proceeds are properly distributed between capital stock and additional paid-in capital.
- e. If company keeps its own stock record books, then:
- Physically review and obtain or prepare a schedule showing certificate number, issue date, to whom issued, number of shares issued, par or no par value, and any restrictions at date of examination.
 - Reconcile schedule to general ledger.
 - Determine that all issued certificates are accounted for as outstanding or cancelled.
 - Account for all certificates not issued.
 - Examine supporting correspondence for stock transfers.
 - Determine that stock certificates, especially blank ones, are adequately safeguarded.
- f. If the company does not keep its own stock record books, then:
- Obtain confirmation of shares outstanding from the register and transfer agent.
 - Reconcile confirmation with general ledger accounts.
- g. For stock options and stock option plans, review Board of Directors minutes for authorization and review the option contracts. Obtain or prepare and test analysis of stock options to include the following information:
- For option plans, the date of the plan, number and class of shares reserved for option, method for determining the option price, period during which options may be granted, and identity of persons to whom options may be granted.
 - For options granted, identity of persons to whom granted, date of grant, number of shares under option, option price, option period, number of shares as to which options are exercisable, and the market price and value of shares under option as of the date of grant or measurement (first date on which are known both the number of shares an individual is entitled to receive, and the option or purchase price, if any).
 - For options outstanding, number of shares subject to option at the beginning of the period, activity during the period (additional shares subjected to options, number of shares exercised under options, number of shares associated with options which expired during the period), and number of shares subject to option at the end of the period.
- h. Identify all stock rights and warrants outstanding as of the examination date, including the number of shares involved, period during which exercisable and exercise price; determine that the rights and warrants were authorized.

- i. Identify any stock subscription receivable and:
 - Determine if they were authorized.
 - Obtain confirmation from subscribers, if appropriate.
 - Ascertain that subscriptions receivable are classified as a reduction of stockholders' equity on the balance sheet.
- j. Obtain or prepare an analysis of the treasury stock account and:
 - Inspect the paid checks and other documentation in support of the treasury stock acquisitions.
 - Examine the treasury stock certificates; ascertain that the certificates are in the plan's name or endorsed to the plan.
 - Reconcile treasury stock to the general ledger.
- k. Ascertain amount of the dividends in arrears, if any, on cumulative preferred shares.

2. Retained Earnings

- a. Analyze activity during the examination period; trace the opening balance to the previous annual audit report; trace net income to the income statement; and, trace unrealized loss on non-current investments to investment working papers.
- b. Determine that dividends paid or declared are authorized by the board of directors and:
 - Determine date of declaration, date of record and date of payment.
 - Examine supporting documents for dividends paid (select checks to shareholders or to a dividend disbursing agent).
 - Re-compute amounts of dividends paid and/or payable.
 - Investigate any prior period adjustments and determine compliance with GAAP. [Refer to FASB-16]
 - Examine supporting documents and authorization for all other transactions in the account, considering conformity with GAAP.
 - Determine compliance with the requirements set forth in Corporations Code 500.
- c. Determine amount of restrictions, if any, on retained earnings at end of period that result from loans, other agreements, or state law.
- d. Determine if any portion of retained earnings is appropriated for potential loss contingencies and recorded in accordance with GAAP. [Refer to FASB-5]

PREMIUM REVENUE AND OTHER INCOME

OBJECTIVES:

- A. Revenue transactions represent consideration for services rendered to subscriber and enrollees in the normal course of business, net of contractual adjustments, in the period for which services are to be contractually provided.
- B. Revenue transactions result in collection of bona fide receivables.
- C. All revenues earned and accrued during the period are recorded and included in the financial statements.
- D. Revenues are properly classified in accordance with GAAP and reported in accordance with the DMHC Financial Report Form instructions. [Refer to FASB Concepts-6]
- E. Results of operations are presented such that prior-period adjustments, dividends and capital transactions are recognized directly in equity; and extraordinary items are disclosed separately in the DMHC Financial Report Form. [Refer to FASB-16 and 130; APB-9, 20, and 30] [See also examination procedures for Operating and Other Expenses]

PROCEDURES:

- 1. Interview appropriate plan personnel and review any written documentation maintained by the plan to gain an understanding of the revenue system. Perform a walk-through of the revenue system and document understanding in the work papers.
- 2. Determine the controls established and monitored by management over the recognition of revenue. Consider the adequacy of these controls. Determine that these controls ensure deductions from revenue are recorded in the proper period.
- 3. Obtain or prepare a comparative analysis of premium revenue, or other revenue account, for the current period and the prior year. Obtain explanations for significant or unusual fluctuations from the prior period. Also compare with plan's prepared budget/forecast for the examination period.
- 4. Identify any revenue from affiliates, or other related parties. Obtain an understanding of their business purpose. Determine that such transactions are appropriately recorded and disclosed in the DMHC Financial Report Form. [Refer to SAS-45].
- 5. Determine premium revenue cut off as of the examination date and perform the following:

- a. Select premium billings for testing from the cash receipts journal for several days before and after the period end. Request supporting records and determine that premium is recorded in the proper period.
 - b. Inquire of the plan as to any unprocessed premium billings, review supporting documents and determine if they should be accrued as of examination period.
 - c. Review a sample of contracts to determine if any adjustments (to include bad debts) to premiums are authorized, controlled and recorded properly, in accordance with respective contracts and plan policy.
 - d. Review a sample of contracts for methods of payment and test plan's computation of revenue and any estimated adjustments to revenue.
6. Trace the following income accounts to separate work paper analysis for examination of the related balance sheet accounts:
- a. Interest income (i.e., notes receivable, debt securities, capitalized leases, etc.).
 - b. Dividend income and realized gains (i.e., marketable equity securities).
 - c. Increase in investments accounted for on the equity method (i.e., investments).
 - d. Gain on sale of property and equipment (i.e., property and equipment).

OPERATING AND OTHER EXPENSES

OBJECTIVES:

- A. Reported expenses include costs that are properly allocable to the current period and are properly matched with revenues.
- B. Administrative costs are properly classified in accordance with Section 1300.78
- C. Results of operations are presented such that prior-period adjustments, dividends and capital transactions are recognized directly in equity; and extraordinary items are disclosed separately in the DMHC Financial Report Form. [Refer to FASB-16 and 130; APB-9, 20, and 30] [See also examination procedures for Premium Revenues and Other Income]
- D. Recognition of appropriate costs and expenses, to include any tax-timing differences and/or extraordinary items, are properly classified in accordance with GAAP and reported in accordance with the DMHC Financial Report Form instructions.

PROCEDURES:

- 1. Interview appropriate plan personnel and review any written documentation maintained by the plan to gain an understanding of the revenue/expense system. Perform a walk-through of the revenue system and document understanding in the work papers. [See examination procedures for Premium Revenues and Other Income.]
- 2. Determine the controls established and monitored by management over the recognition of expenses. Consider the adequacy of these controls. Determine that these controls ensure expenses are recorded in the proper period.
- 3. Obtain or prepare a comparative analysis of each expense classification for the current period and the prior year. Obtain explanations for significant or unusual fluctuations from the prior period, based on percentage of revenues and account balances. Also compare with any plan prepared budget/forecast for the examination period. The following should be considered:
 - a. Each classification of expenses analyzed as a percentage of revenues.
 - b. Schedule to identify the individual account balance comprising each classification in the income statement.
 - c. Consider whether the classification of expenses is in conformity with GAAP.
- 4. Trace the following expense accounts to separate work paper analysis for examination of the related balance sheet accounts:

- a. Bad debt expense (i.e., allowance for doubtful accounts-trade receivables).
 - b. Insurance expense (i.e., prepaid insurance).
 - c. Property taxes (i.e., prepaid and/or accrued property taxes).
 - d. Depreciation expense (i.e., property and equipment, accumulated depreciation).
 - e. Amortization costs (i.e., intangible assets).
 - f. Interests expense (i.e., notes payable, long-term debt, capitalized leases).
 - g. Provisions for income taxes (i.e., liability for income taxes currently payable, deferred income taxes).
 - h. Realized losses on current investments (i.e., marketable equity securities).
 - i. Loss on sale or disposition of property and equipment (i.e., property and equipment).
5. Obtain or prepare analyses of the following accounts and examine supporting detail on a complete or test basis, as deemed appropriate.
- a. Professional fees (i.e., information regarding outstanding fees for legal services are obtained during work on commitments and contingencies concerning pending litigation and should be traced to determine properly paid or accrued in the examination period).
 - b. Rent and royalty expense (i.e., related to examination of leases and other agreements).
 - c. Executive and Officer Compensation (i.e., authorized by the Board of Directors).
 - d. Maintenance and repairs (i.e., review during work on property and equipment; determine that expenses do not include amounts to be capitalized).
6. Review expenses to determine that all administrative costs are classified in accordance with Section 1300.78. [See Statutory Compliance for Administrative Costs]

SUBSEQUENT EVENTS

OBJECTIVES:

- A. Relevant events or transactions are identified and evidential matter is collected that pertain to events that occur subsequent to the examination period through the last date of fieldwork.
- B. Events or transactions resulting from evidence provided through review for subsequent events are appropriately adjusted or adequately disclosed accordance with GAAP and the DMHC Financial Report Form instructions. [Refer to SAS-1, 58]

PROCEDURES:

- 1. Review interim DMHC Financial Report Form or other internal financial statements that are prepared by Plan subsequent to examination date:
 - a. Compare them with the financial statement period under examination and with the prior audited financial statement; and make any other comparisons considered appropriate in the circumstances.
 - b. Request and review any journal entries made after the prior year-end for unusual amounts, unusual activity or other unusual characteristics.
 - c. Inquire of officers and other executives having responsibility for financial and accounting matters as to whether the interim statements are prepared on the same basis as the statements under examination.
- 2. Inquire of and discuss with officers and other executives having responsibility for financial and accounting matters as to whether:
 - a. Any material contingent liabilities or commitments existed at the examination date or at the date of inquiry.
 - b. Any significant change has occurred since the examination date in stockholder's equity, long-term debt, or working capital.
 - c. Any significant changes in estimates with respect to the amounts included or disclosed in the financial statements being examined.
 - d. Any material adjustments were made after the examination date to the date of inquiry.
- 3. Request and read the minutes of stockholders, directors, and other committees, that were not previously available during the period subsequent to the examination date. Inquire about matters dealt with at such meetings, as appropriate.

4. Assemble pertinent findings from review of legal inquiries from Plan's legal counsel and other auditing procedures concerning litigation, claims, and assessments. If deemed appropriate, obtain additional evaluation from Plan's legal counsel.
5. Obtain a letter of representation from plan's management (usually the Chief Financial Officer or Chief Executive Officer) regarding any events that occurred since the examination date through the last day of fieldwork. [Refer to SAS-19]
6. Make such additional inquiries or perform such procedures deemed necessary and appropriate, as a result of the foregoing procedures, inquiries and discussions.

SECTION III. STATUTORY COMPLIANCE

As part of the routine financial examination, the examiner must determine a plan's compliance with a number of statutory requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 and Title 28, Division 1, Chapter 1 of the California Code of Regulations. The Act and the Regulations are amended on an annual basis, so it is incumbent on the examiner to ensure that these amendments are considered in their performance of the Statutory Compliance work papers and other sections, as appropriate.

This Examiner Guide is updated for amendments to the Act and Regulations as they become effective.

A separate notebook, or section of a notebook, should be established as part of the examiner's work papers with the Statutory Compliance Index at the front. The work papers are designated with the prefix "SC" and follow the Statutory Compliance Index that summarizes the date the work paper was completed, the examiner's initials, exceptions noted and work paper reference number.

WORKPAPER PREPARATION:

Each Statutory Compliance work paper is to cite the Section and Rule to which the work refers. This should be followed by the procedures performed; a narrative summary of the examiner's findings; and, the conclusion reached as to compliance with the specific Section or Rule.

When the Section or Rule refers to numerical quantities or required calculations, the work paper must provide the required calculation that demonstrates compliance or non-compliance.

FINANCIAL VIABILITY

TANGIBLE NET EQUITY (“TNE”)

OBJECTIVE:

Determine compliance with Sections 1376, 1376.1 and Rules 1300.76, 1300.76.1.

PROCEDURES:

1. Obtain a copy of the plan's work paper that supports the calculation of required TNE in the Supplemental Information accompanying the DMHC Financial Report Form.
2. Discuss the work paper and methodology used in the calculation with plan personnel.
3. Review Rule 1300.76 requirements and determine accuracy of the Plan's calculation of required TNE.
4. Review the trial balance and determine if medical expenses are correctly categorized as “capitated”, “non-capitated”, “per diem”, and/or “fee-for-service”. If medical expenses are presented on the “aggregate write-in” line item, then investigate to determine proper categorization. The proper categorization of medical expenses is important to determine whether the Plan's calculation of required TNE based on the Health Care Expenditures method is correct. [Refer also to DMHC Report Form instructions]
5. If examiner determines there is a material misstatement of the required TNE by the plan, then the examiner discusses proper calculation with the plan and requests the plan to revise their calculation. The examiner is to determine if the plan needs to amend prior financial statement filings with a revised TNE calculation.
6. Determine that all intangible assets, as defined in Rule 1300.76 (e) are excluded in calculating TNE compliance.
7. Review all transactions with officers, directors, owners or affiliates for resulting affiliate/intercompany receivables. Determine if resulting receivables are properly classified as “Unsecured” or “Secured”, as follows:
 - a. Unsecured receivables are excluded in calculating tangible net equity—both “current” and “long-term”, unless determined to be in the normal course of business and not past due. “Past due” for TNE calculation purpose is considered to be over 60 day old.
 - b. Secured receivables must be collateralized by tangible assets, in accordance with Rule 1300.76 (e), and proper documentation must be filed as an amendment with and be approved by the DMHC **prior** to recognizing it as “Secured” in the TNE calculation. The Plan must demonstrate that the equity in the tangible asset is 110% of the receivable amount.

Documentation is to include, but not be limited to, the following:

- For real property (i.e., land/building): promissory note, board resolution, current appraisal of property, outstanding balance on all liens, title policy and recorded trust deed.
- For collateral other than real property: promissory note, board resolution, current appraisal of property, outstanding balances on all liens, and verification that the plan has an enforceable lien against the property (i.e., Uniform Commercial Code Filing with Secretary of State)

[Refer also to DMHC Report Form instructions and to Examination Procedures for Notes Receivables and/or Affiliate Receivables & Due to/Due from Affiliates]

8. Determine if intercompany receivable is “net” amount due to offsetting arrangements. The Department requires a written Right of Offset agreement to be in place to properly document the enforceability of a setoff arrangement. Without a written Right of Offset, an intercompany receivable is to be recorded at “gross” and deducted from TNE if it is not secured. [Refer to FIN 39] [See also Affiliate Receivables & Due to/Due from Affiliates]
9. Determine that subordinated debt was filed with and approved by the DMHC **prior** to including it in the TNE calculation. Any operating cost assistance or direct loan made to a plan by the United States Center for Medicare and Medicaid Services pursuant to Public Law 93-222, as amended, may be treated as a subordinated loan, notwithstanding any express terms thereof to the contrary.
10. Calculate required TNE and the TNE position based on the financial statement per examination.
11. For a plan operated by a county, or city and county, determine if it meets the requirements of Section 1376.1 (a) and (b). If so, then Rule 1300.76.1 will not apply.

FISCAL SOUNDNESS

OBJECTIVE:

Determine compliance with Section 1375.1 and Rule 1300.75.1.

PROCEDURES:

1. Review the overall results of the examination findings that provide evidence as to the financial solvency of the plan, such as working capital position, provision for current and future indebtedness, cash flows, net income/losses, administrative expenses, and prompt payment/denial of provider/enrollee claims.
2. Review the financial soundness of the plan's arrangements for health care services and the schedule of its rates and charges for premiums to subscribers and compensation to providers. Determine that the terms of the provider contracts address obligations to subscribers/enrollees in the event of plan solvency. Determine that the plan controls and monitors the utilization of health care services. Consideration should be given to requesting a breakdown of revenues and expenses by line-of-business, and utilization reports.
3. Perform analytical review using the Financial Statement per Examination for financial ratios to include, but not be limited to, the following:
 - a. Current ratio (Current Assets / Current Liabilities)
 - b. Quick or Acid Test ratio (Cash + Marketable Securities + Receivables / Current Liabilities)
 - c. Days Cash on Hand (Cash + Marketable Securities x 365 / Total Operating Expenses - Depreciation)
 - d. Profit and Loss Trend (Profit or Loss / Total Revenues)
4. Document if the plan has reinsurance coverage to cover a portion of high dollar claims.
5. Determine compliance with Rule 1300.75.1 (b) (1)-(3)
6. Determine if any arrangements with affiliates impact plan's ability to comply with this requirement.
7. Provide written statement as to the basis for and the conclusion reached in this work paper.

DEPOSIT REQUIREMENTS

1. RESTRICTED DEPOSIT

OBJECTIVE:

Determine compliance with Section 1376 and Rule 1300.76.1.

PROCEDURES:

1. Obtain copies of the instruments and assignment forms from the Plan and compare with forms on file with DMHC.
2. Determine that the proper assignment form was used and it was properly completed and executed.
3. Determine that the funds are fully insured by the bank, which requires a full service plan to establish three accounts in three different banks due to FDIC limits.
4. Determine if the exemptions in Section 1376.1 apply to the Plan.
5. Determine that a deposit invested in Treasury Bills ("T-Bill") is in an amount in excess of the deposit requirement to ensure that the value of the T-Bill does not fall below the required deposit amount of \$300,000 for full service plan or \$50,000 for specialized plan.
6. Determine that any withdrawals or substitutions were properly filed with the DMHC and approved.

2. CASH AND CASH EQUIVALENTS DEPOSIT

OBJECTIVE:

Determine compliance with Section 1377 and Rules 1300.77 and 1300.77.3.

PROCEDURES:

1. Obtain the plan's work papers that support line items 26 to 38 of the Supplemental Information that accompanies the DMHC Financial Report Form for the examination period.
2. Discuss the applicability of cash and cash equivalents with plan personnel. If the plan does not have work papers, then prepare a work paper to determine compliance with Section 1377.

3. Test the accuracy of the plan's work papers by tracing to appropriate supporting schedules. Determine whether the work papers meet the requirements of Rule 1300.77.3. Verify that the claims data on the work papers is reasonable. If under 10%, then no further work is necessary.
4. If a plan falls within the cash and cash equivalents requirements and
 - a. Maintains a deposit:
 - Determine that the deposit is reasonably estimated as of the first day of the month and maintained for the remainder of the month. [See Rule 1300.77.3]
 - Obtain copies of the insolvency deposit instrument and assignment forms and compare with those on file with the DMHC.
 - Determine whether the deposit amount meets the requirements of Section 1377 (a) (1) (A) and Rule 1300.77 (b).
 - Determine that any withdrawals or substitutions were properly filed with the DMHC and approved.
 - b. Maintains insurance or guaranty arrangement:
 - Determine if guaranty arrangement was filed with and approved by DMHC.
 - Determine that insurance complies with Rule 1300.77 (a).
5. If plan falls within the cash and cash equivalents requirements for the first time, then determine if the plan filed a written report with the DMHC within 30 business days from the first day of the month for which reimbursements exceeded 10%, in compliance with Section 1377 (b) and Rule 1300.77.3 (c).

INSURANCE

OBJECTIVE:

Determine compliance with Section 1351 (o) to (r), 1375.1 and Rules 1300.51(d) (HH), 1300.75.1, 1300.76.3.

PROCEDURES:

1. Fidelity Bond
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. Insurance must meet a certain minimum limit of coverage and deductible.
 - e. Insurance must include specific language outlined in Rule 1300.76.3(a). Cancellation notice must not use any language that allows for the insurer to make a decision not to provide this notice (i.e., “endeavor”).
 - f. Determine that the plan has exclusive right to the specific amount of coverage if it is included as a named insured of an affiliate.
 - g. If the carrier is located offshore, then determine if it is licensed in California and require the plan to demonstrate the fiscal soundness of the carrier.
 - h. Present a conclusion regarding compliance for the period under review.
2. Malpractice Insurance
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. Determine that the plan has exclusive right to the specific amount of coverage if it is included as a named insured of an affiliate.

- e. The minimum coverage should be at least equal to the amount that the plan requires of its providers.
 - f. Present a conclusion regarding compliance for the period under review.
- 3. Property
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. The plan has sufficient coverage if it is included as a named insured of an affiliate.
 - e. Present a conclusion regarding compliance for the period under review.
- 4. Workers' Compensation
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. The plan has sufficient coverage if it is included as a named insured of an affiliate.
 - e. Present a conclusion regarding compliance for the period under review.
- 5. Liability
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. The plan has sufficient coverage if it is included as a named insured of an affiliate.
 - e. Present a conclusion regarding compliance for the period under review.

6. Reinsurance
 - a. Obtain insurance policy.
 - b. Determine that policy is current.
 - c. Document the name of the insurer, the insured, the coverage period and the terms of the policy.
 - d. Determine compliance with Section 1375.1(a)(2) and Rule 1300.75.1((b).
 - e. Present a conclusion regarding compliance for the period under review.

ADMINISTRATIVE CAPACITY

1. ADEQUACY OF ADMINISTRATIVE CAPACITY

OBJECTIVE:

Determine compliance with Section 1367 (g) and Rule 1300.67.3

PROCEDURES:

1. Review completed management assessment questionnaires and schedule interviews with management positions that completed the questionnaires. [See Management Questionnaire procedures]
2. Review summary of Board of Director minutes prepared at start of examination. Document and cross-reference to Board of Director minutes work paper as to whether significant, material transactions and policies were discussed and approved by the Board.
3. Interview appropriate plan personnel and review organizational charts and obtain an understanding of the plan's organizational structure for plan functions and management functions:
 - a. Determine and document the ministerial and/or discretionary functions that are delegated through administrative service agreements to affiliates or other entities and the location at which they are provided (i.e., out-of-state). [Coordinate review with Statutory Compliance for Affiliate Contracts and Affiliate Transactions to avoid duplication of work.]
 - b. Document the oversight and monitoring activities the plan has in place for overseeing each delegated function, to include:
 - The management position with responsibility of oversight.
 - The type of reports and timeframes for reports to be filed with the plan.
 - The type and frequency of physical "on-site" monitoring performed by the plan.
 - c. Document the control the plan has over discretionary functions (e.g., Adjusting Journal Entries are to be prepared and approved/signed by plan management, while an affiliate may input it into the general ledger system.)
4. Document and cross-reference to Statutory Compliance for Financial Viability work paper as to whether the plan demonstrated administrative services that result in effective conduct of plan's business considering the plan's financial viability.

5. Document and cross-reference to Internal Control work paper as to whether the plan has retained control over ministerial and/or discretionary functions, when affiliates are performing administrative functions on behalf of the plan.
6. Document and cross-reference to Statutory Compliance for Books and Records work paper as to whether the plan has access to books and records that support administrative functions performed by affiliates on behalf of the plan.
7. Determine the existence and review written procedures (i.e., policy and procedure manuals for accounting, claims, etc.) maintained by the Plan for the conduct of the plan's business as it relates to the Financial and Accounting aspects. Document the findings and provide support, as appropriate.
8. Determine that separation exists between medical services and fiscal/administrative management. (e.g., high dollar claims undergo final review and approval for payment by CFO would indicate potential influence over medical decisions by fiscal management). Document the findings and provide support, as appropriate.
9. At completion of fieldwork, evaluate management's ability to effectively conduct the Plan's business considering factors such as financial viability, oversight and control over delegated ministerial and/or discretionary functions, when affiliates or other third parties are performing administrative functions on behalf of the plan. Also, an evaluation must be made as to whether the plan's provision of administrative services to an affiliate or other third party impacts its ability to comply with financial and administrative capacity requirements. Document the findings and provide support, as appropriate.

2. ADMINISTRATIVE CONTRACTS

OBJECTIVES:

Determine that all ministerial and discretionary administrative services delegated to or performed by affiliates or other third parties on behalf of the plan are documented by a written contract. Determine all administrative services performed by the plan on behalf of an affiliate or other third party is documented by a written contract. Determine that all contracts are in compliance with Sections 1351 (d), 1367 (h) and Rule 1300.51 (d) (F) (2), (3) and (d) (N).

PROCEDURES:

1. Obtain and review all administrative service contracts. Prepare or obtain a summary of key points from these contracts. These contracts are to document the oversight and monitoring activities the plan has in place for overseeing each delegated function, to include but not limited to the following:

- a. The management position with responsibility of oversight.
 - b. The type of reports and timeframes for reports to be filed with the plan.
 - c. The type and frequency of physical “on-site” monitoring performed by the plan.
2. Interview appropriate plan personnel and obtain an understanding of all contracts.
3. Determine that contracts were filed and approved by the DMHC.
4. Review the plans operations for compliance with the contracts.
5. Document any arrangements not evidenced by a contract.
6. Determine or require plan to demonstrate that compensation rates are fair, reasonable and relate to the services being performed.
7. Present a conclusion regarding compliance for the period under review.

3. MANAGEMENT CHANGES

OBJECTIVE:

Determine compliance with Section 1352 (c) and Rule 1300.52.2.

- Management changes include additions or deletions of directors, trustees, principal officers, key management staff, owners/shareholders, and principal creditors.

PROCEDURES:

1. Make inquiries to President/CEO as to any management changes during the past year.
2. Review Board of Director minutes for any changes in directors or key management of the plan. Make appropriate cross-references on this work paper and Board of Director Minute work paper.
3. Determine if amendment filings were made with DMHC for any management changes within the five (5) day requirement of Section 1352 (c).
4. Present a conclusion regarding compliance for the period under review.

ADMINISTRATIVE COSTS

OBJECTIVE:

Determine compliance with Section 1378 and Rule 1300.78.

PROCEDURES:

1. Obtain the plan's supporting work papers that support the administrative cost percentage calculation prepared in the Supplemental Information that accompanies the DMHC Financial Report Form for the examination period.
2. Review Rule 1300.78 for identification of those costs to be considered administrative costs.
3. Review the DMHC Financial Report Form Report #2: Revenue, Expenses and Net Worth for account classifications that are **not** identified as administrative cost to verify that they are appropriately classified as a medical and hospital expense. If not, then consider if an examination adjustment is necessary to re-classify the expense as an administrative expense.
4. An analysis of administrative expenses and revenues must be completed to determine compliance with the administrative cost requirements. The examiner must isolate costs and revenues that are not related to or obtained from subscribers or enrollees of the plan in determining the administrative cost percentage. Revenue not derived from subscribers or enrollees of the Plan may be used to offset administrative costs (i.e., net income from fee-for-service revenues from patients not subscribers of the Plan; rental income; net income from other lines of business exempt from Knox-Keene requirements). Administrative expenses relating to "non-subscriber/enrollee" revenues are not to be included.
5. Prepare a calculation of administrative costs based on the financial statement balances at the conclusion of the examination. This provides for consideration of the impact of any examination adjustments.
6. If the administrative costs of an established plan exceed 15 percent, or 25 percent for a plan in the development phase, prior to the start of the examination, the Department shall request through its initial notification letter that the plan to demonstrate to the Department that its administrative costs are not excessive within the meaning of Section 1378 and are justified under the circumstances; and/or, that the plan has instituted procedures to reduce administrative costs which are proving effective. If the plan exceeds these established guidelines as a result of examination adjustments, then the Department will request a justification in the Preliminary Report.
7. Evaluate the reasonableness of the written justification provided at the start of the examination, if applicable. Determine if any additional follow-up is required.
8. Present a conclusion regarding compliance for the period under review.

CLAIMS

The Examiner's review of Statutory Compliance for claims should be coordinated with the procedures required under the review of the balance sheet accounts for claims liabilities to reduce any duplication of work.

1. INCURRED BUT NOT REPORTED CLAIMS ("IBNR")

OBJECTIVE:

Determine compliance with Section 1377 (c) and Rules 1300.77.1, 1300.77.2 and 1300.77.3

PROCEDURES:

1. If the plan does not report an IBNR claims liability in its balance sheet and it pays claims on a fee-for-service basis, then determine whether the plan is required to estimate and record in its books a liability for IBNR claims, pursuant to Section 1377 (c). Obtain from plan or perform calculation to determine if the plan reimburses providers or subscribers/enrollees on a fee-for-service basis to an extent that exceeds 10 % of its total health care expenses for the examination period.
2. Review procedures performed for the balance sheet accounts for claims liabilities and determine plan's compliance with Rule 1300.77.1 and 1300.77.3. Cross-reference as appropriate to this work paper.
3. Determine that plan's method of calculating its estimated claims liability for IBNR is a method held unobjectionable by the DMHC, pursuant to Rule 1300.77.2.
4. Perform procedures contained in the TAG or Technical Assistance Guide for Assessment of Health Plan Management of Claims that relate to the above Section and Rules.
5. Utilize detailed ACL Software guidelines as appropriate in performance of TAG.
6. Document findings in the work paper and provide any support, as appropriate.
7. Present a conclusion as to compliance for the period under review.

2. ACCOUNTABILITY OF THE STATUS OF A CLAIM

OBJECTIVE:

Determine compliance with Rule 1300.77.4.

PROCEDURES:

1. During performance of the walk-through and review of the claims processing system, which are performed as part of the procedures for the balance sheet accounts for claims liabilities, the examiner needs to determine that procedures are in place that permit the plan to determine the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claims.
2. Perform procedures contained in the TAG or Technical Assistance Guide for Assessment of Health Plan Management of Claims that relate to the above Rule.
3. Utilize detailed ACL Software guidelines as appropriate in performance of TAG.
4. Document findings in the work paper and provide any support, as appropriate.
5. Present a conclusion as to compliance for the period under review.

3. CLAIM REIMBURSEMENT AND SETTLEMENT PRACTICES

PDR review should be completed first to identify potential systemic claim issues, so that selection of claim sample will include these claims to confirm or dispute the existence of these systemic issues.

OBJECTIVE:

Determine compliance with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, 1399.55; and Rules 1300.71 and 1300.71.4

Medicare claims are exempt from these Sections and Rules.

PROCEDURES:

1. Request and obtain the following claims data:
 - a. Record layout (description of all data fields) and understand the record layout.
 - b. Electronic claims data from the plan for three consecutive months (i.e. 4/1/04 through 6/30/04) to include paid, denied, reprocessed or prior paid/denied, pended, and currently waiting to be processed (at the time of the data extract) on a CD in DBASE, Access, or Text delimited format. Claims data should include, at a minimum, the following fields:
 - Claim number (or an unique number to identify a claim)
 - Date of service (from and to dates)
 - Date received

- Date paid
- Date of the letter to provider for contested claims
- Type of letter sent (i.e. COB information request, request for medical records, and etc.)
- Date received the response
- Date(s) for each EOB (if a claim was processed three times, please provide three dates associated with each RA/EOB.)
- RA/EOB explanation code and description
- Provider (Vendor) name and number
- Patient Status (i.e. subscriber, dependent, and etc.)
- Check number
- Amount billed
- Amount paid
- Withholds
- Withhold code
- Interest paid
- Any other \$ fields
- Date of interest paid (If interest is paid separately)
- Interest payment check number (If interest is paid separately)
- Interest payment check amount (If interest is paid separately)
- Provider Status (i.e. contracted or non-contracted providers, or in-network /out-of-network)
- Provider type (i.e. hospital, professional, specialist, and etc.)
- Claim Status (i.e. paid, pending, denied, adjusted, waiting to be processed, and etc.)
- Pending or denied codes, other system generated codes
- Service Type (i.e. Emergency, Out-of-area, Trauma, Surgery, In-Patient/Out-Patient, and etc.)
- Place of Service
- Denial Reasons
- Adjusting and/or not covered reasons
- Indicator(s) for appealed and paid claims (reprocessed) with prior partial payments or denials.
- Indicator(s) for encounter claims
- Member ID#
- Line of business
- Notes and/or comments

Items pertaining to Rule 1300.71:

- Identifier for paper or electronic claims
- Identifier for claims received in error, plan's claims, or dispute
- Date of acknowledgement of receipt
- Date of redirection of claims received in error

- Date of claims pended
 - Date of claims released from pending status
 - Date Dispute submitted
 - Date Dispute acknowledged
 - Date of Resolution and Written Determination of Dispute
2. Verify completeness of claims data received and eliminate duplicate records using ACL Software procedures.
 3. Complete walk-through and review of the claims processing system, which are performed as part of the procedures for the balance sheet accounts for claims liabilities, to gain understanding of plan's claims operations. [Reference to Examination Procedures for Claims Liabilities]
 4. Perform procedures contained in the TAG or Technical Assistance Guide for Assessment of Health Plan Management of Claims that relate to the above Sections and Rules.
 5. Utilize detailed ACL Software guidelines as appropriate in performance of TAG.
 6. Review of individual claims should include the following:
 - a. Review the entire history related to the claim, not only the events related to the claim payment selected.
 - b. Obtain a print out for each claim sample selected, to include the following:
 - Provider name or number
 - Claims number
 - Date of service
 - Date of payment
 - Check number
 - Billed amount
 - Allowed amount
 - Co-payment amount
 - Withheld amount
 - Paid amount
 - c. Request the related provider contract for the claim sample selected. [See Statutory Compliance for Provider Contracts]
 - d. Set up a spreadsheet work paper to document the performance and findings related to the review for compliance as follows:

- Verify claim payment timeliness and payment of related interest and penalties on late claims with Sections 1371 and/or 1371.35 and Rule 1300.71.
- Verify provider contract compliance with Section 1379 and with Rule 1300.67.8.
- Verify that the information on the individual claims agrees with the information contained in the plan's disbursement detail.
- Verify that the amount of any withhold agrees with the contractual arrangements for that provider.
- Verify that the amount "allowed" (i.e. contracted amount) on the claim agrees with the contractual arrangements with that provider.
- Verify that the amount paid on the claim agrees with the provider contract, on a test basis for various types of providers (e.g. individual provider, specialist, IPA or medical group, hospital, ancillary, etc.)
- Compare date of check with date check cleared the bank to determine whether plan is "holding" claim checks.
- Compare the claim's "Received Date" with the date that the Provider signed the claim. If there is more than 20 days between date of Provider's signature and Date of Receipt, perform additional procedures to determine whether the Plan is date-stamping the claim with the correct date.
- Specific areas identified under Rule 1300.71 that are not addressed above [Refer to the TAG].

7. Review of unpaid claims should include the following:

- a. Request aging schedule of all claims that are unpaid at examination date.
- b. Select a number (at least 20) of claims to review. The claims reviewed should include claims from all types of providers and should include all dollar levels.
- c. Review copies of the plan's correspondence and comments recorded in the Claims System relating to each selected claim for compliance with the notification requirements of Sections 1371 and 1371.35; and Rule 1300.71.

8. Review of denied and pended claims should include the following:

- a. Obtain schedule of denied and pended claims.
- b. Review the "Pend Reports" reports that identify the dollar amount of the claim and the reason for pending or not paying it. Identify unusual categories for pending a claim. Investigate an unusually high number of pended claims in one category.
- c. Compare the total dollar amount of claims pended to total claims payable for reasonableness.

- d. Review "Denial Reports" that identify the dollar amount of claim and the reason for denial. Identify unusual categories for denying a claim. Investigate an unusually high number of denied claims in one category.
 - e. Review individual denied claims on a sample basis to determine whether denials were appropriate.
- 9. Document all findings in appropriate work papers and provide any support, as necessary.
 - 10. Present a conclusion as to compliance for the period under review.

4. COMPENSATION OF CLAIM REVIEWERS

OBJECTIVE:

Determine compliance with Section 1399.56.

PROCEDURE:

Determine that claim processors or reviewers are not compensated in a manner that provides an incentive to reduce payment of the claims.

REPORTING REQUIREMENTS

1. MONTHLY REPORTING

OBJECTIVE:

Determine compliance with Section 1384 (f) and (i); and Rule 1300.84.3 (and as relates to Rules 1300.84.06 and 1300.84.2.)

PROCEDURES:

1. Determine that the plan has internal procedures that provide one or more of its principal officers on at least a monthly basis the information necessary for the reports required by Rule 1300.84.3 (b) to (d) to be completed.
2. Review the plan's financial statement and the financial statement at the conclusion of the examination to determine if events occurred that would require monthly reporting pursuant to 1300.84.3 (d).
3. Determine that all necessary reporting requirements are met by the plan.
4. Present a conclusion regarding compliance for the period under review.

2. COMBINED REPORTS

OBJECTIVE:

Determine compliance with Rule 1300.84 (c), (e) and (f).

PROCEDURES:

1. See procedures 1 to 5 of Statutory Compliance for Affiliate Transactions.
2. Obtain description from plan as to types of financial and/or administrative transactions that occur between the entities.
3. Verify these transactions in review of intercompany receivables and payables, subordinated debt, etc. [See Affiliate Receivable procedures]
4. Obtain and review current financial statements from each affiliated entity.
5. Provide narrative description to support determination as to common control (direct, indirect or none) for each affiliate identified.

6. Provide narrative description and any necessary calculations (i.e., percentage of revenue from plan to affiliate's total revenue; percentage of plan enrollment using affiliates services, etc.) to support determination as to dependency for services or revenues (direct, indirect or none) between the plan and the affiliate or visa versa.
7. Provide conclusion as to findings from procedures 5 and 6 and determine if combined reporting is required. Finding must support that there is common control **AND** dependency for services or revenue.
8. If plan is required to file combined financial statements, then review the annual audited report and determine that it covers all entities pursuant to Rule 1300.84 (e). Document findings.
9. If the plan has subsidiary companies and is required to file consolidated financial statements, review and determine that these financial statements comply with Rule 1300.84 (f). Document findings.

3. SPECIAL REPORTS

OBJECTIVE:

Determine compliance with Section 1384 (d).

PROCEDURES:

1. Interview plan's personnel and obtain an understanding of plan structure and operations.
2. Review the plan's financial statement and the financial statement at the conclusion of the examination to determine if events occurred that would require special reports to be filed pursuant to Section 1384 (d).
3. Provide all narrative disclosure to support this requirement.
4. Present a conclusion regarding compliance for the period under review.

4. ANNUAL AND QUARTERLY FINANCIAL PRESENTATION IN DMHC FINANCIAL REPORT FORM AND SUPPLEMENTAL INFORMATION

OBJECTIVE:

Determine compliance with Section 1345 (s) and 1384 (f) and (i) and Rule 1300.84.06 (and as relates to Rules 1300.84.2 and 1300.84.3).

PROCEDURES:

1. Review DMHC Financial Report Format (i.e., balance sheet, income statement, cash flow statement and all required schedules) for period under examination to determine that all line items are properly reported and completed in compliance with the DMHC “General Information, Definition, and Instructions” (“Instructions”) and the above Regulation.
2. Review the Supplemental Information and determine that all items are properly supported and completed by the plan in compliance with the Instructions and the related Act and Rules.
3. Determine that the details of accounts receivables from officers, directors, owners or affiliates are properly disclosed in the Supplemental Information and agree with supporting documentation obtained from the plan. [See examination procedures for Accounts Receivable and/or Payable to Affiliates]
4. Determine that affiliate receivables are presented on the proper line item in Report #1—Part A: Assets of the DMHC Financial Report Form (Secured, Unsecured, Current, Long Term or Past Due) and that proper disclosure is made in the footnotes as required by GAAP and the Instructions.
5. Trace amounts presented on Schedules A to L back to related Balance Sheet accounts, as appropriate.
6. Review DMHC Annual Financial Reporting Form to determine that “General Interrogatories” are completed and tie out with information/documentation gathered during the examination.
7. At the conclusion of the examination, determine that the plan’s DMHC Financial Report Format was prepared in accordance with GAAP as required by Section 1345 (s).
8. Present a conclusion as to compliance for the period under review.

5. ENROLLMENT**OBJECTIVE:**

Determine compliance with Section 1356.

PROCEDURES:

1. Obtain from the plan supporting schedules for enrollment and utilization data presented in Report #4 of the DMHC Financial Report Format for the examination period and for the preceding period ended March 31.

2. Trace the numbers to the plan's records, and verify that the plan's method of tracking enrollment and utilization is reasonable and reliable.
3. Verify that enrollment includes subscribers and the actual number of dependents. If the plan (i.e., behavioral) does not collect this data, the plan shall provide the department with an estimate of the number of enrollees and the method used for determining the estimate. [Refer to Section 1356 (b) (4)]
4. Verify that enrollment includes all enrollees that are receiving services under an arrangement made by another plan or plans, whether pursuant to a contract, agreement, or otherwise. [Refer to Section 1356 (e)]
5. When the plan has affiliate health plans located in other states, then verify whether the total enrollment includes those enrollees who are located in California, but whose employer is located in another state. (The plan may refer to the employer as the "control group" and premium is forwarded from an affiliate plan in the other state to the California plan for these enrollees.)
6. Trace enrollment information for March 31 to Plan's supporting documentation. Determine whether material differences in enrollment exist at this date and research difference with the Plan. If difference is material, then DMHC assessment payment may not be adequate. Discuss with Oversight Examiner to determine appropriate action. [revised 10-12-05]
7. Determine that cumulative enrollment is calculated and reported correctly in Report #4 for the examination period.
8. Obtain the plan's policy for requiring enrollees to select a PCP or dentist (provider).
9. Obtain the plan's policy for assigning enrollment and for paying retro capitation.
10. For unassigned enrollees, consider the following:
 - a. Obtain a list of unassigned enrollees (enrollees who have not selected a provider) for the financial statement date being reviewed.
 - b. Determine if the unassigned enrollees list include enrollees who are not presently assigned to a PCP or dentist. If not, obtain a list of these unassigned enrollees.
 - c. Determine that the plans included the unassigned enrollment in its enrollment number.
 - d. Coordinate review with Examination Procedures for Capitation Payable.

11. Present a conclusion as to compliance for the period under review.

6. CANCELLATION OF ENROLLMENT

OBJECTIVE:

Determine compliance with Section 1365 and Rule 1300.65. All plans must comply with the requirements of this Section and Rule, except for plans that have applied for, and received, a conditional exemption from the requirements of Section 1365 (a) (1) and Rule 1300.65. [As of July 2004, PacifiCare of California is the only plan that has received an Order of Conditional Exemption.]

PROCEDURES:

1. Obtain the plan's termination policies and procedures, review and discuss with plan personnel, as appropriate. Determine compliance with Act and Rule.
2. Request a list of terminated subscriber groups from a one-year period ending with the financial statement date being examined.
3. Select a sample of terminated subscriber groups and request copies of the notices that were sent to the terminated groups.
4. Verify that the cancellation and coverage termination dates, per the notice, are not less than 15 days subsequent to the date of the notice.
5. For the same sample of terminated subscriber groups, verify that either:
 - a. The plan itself has notified the individual enrollees of the termination of coverage.
 - b. The plan has instituted procedures to ensure that the terminated employer group has notified the affected individual enrollees.
6. Present a conclusion as to compliance for the period under review.
7. Refer to the Office of Enforcement any retroactive termination violations.

BOOKS AND RECORDS

OBJECTIVES:

Determine compliance with Sections 1381, 1385 and Rules 1300.81, 1300.85 and 1300.85.1.

PROCEDURES:

1. At the start of the examination, determine that the plan's books and records are maintained on a current basis and are open to inspection by the Department during normal business hours.
2. Obtain the plan's procedures for maintaining books and records in compliance with the above Act and Rules. Discuss with appropriate plan staff. Determine the location of all books and records of the plan and any management company, solicitor, solicitor firm and any provider or subcontractor providing health care or other services to the plan.
3. During the examination, determine that books and records requested from the plan for up to the last two years are located in an easily accessible place at the offices of the plan and are provided within a reasonable time frame, up to two (2) days after requested. Books and records requested that are over two years old are made available to the DMHC examiner staff within not more than five (5) days after requested.
4. Determine that the specific records identified in Rule 1300.85 (b) are maintained by the plan.
5. Determine whether any of the books and records of the plan, management company, solicitor, solicitor firm and any provider or subcontractor providing health care or other services to the plan are located outside the State of California. If so, determine that the plan obtained prior consent from the DMHC. [Refer to Rule 1300.81]
6. If books and records are located out of state, then the Department, upon reasonable notice, may require that such books and records be made available for examination in this state. The DMHC would expect that these out of state records be made available to the DMHC examiner staff within not more than five (5) days after a request is made.
7. Present a conclusion as to compliance for the period under review.

CONTRACTS/AGREEMENTS

1. PROVIDER CONTRACTS

OBJECTIVE:

Determine compliance with Sections 1348.6, 1379(a), 1381, and 1385; and, Rule 1300.67.8 (a) to (e).

PROCEDURES:

1. Obtain and review generic/specimen provider contracts to determine if:
 - a. It contains any incentive payment as an inducement to deny, reduce, limit or delay medically necessary or appropriate services to enrollees. If so, this is a violation of Section 1348.6 (a).
 - b. It requires the provider to maintain records and provide access to the Director, and retain records for at least 2 years. If not, this is a violation of Rule 1300.67.8 (b).
 - c. It provides that the plan have access to the books, records and papers of the provider relating to the health care services provided to enrollees, the cost thereof, to payments received by the provider from subscribers/enrollees (or from others on their behalf) and to the financial condition of the provider, unless provider is paid on a fee-for-service basis. If not, this is a violation of Rule 1300.67.8 (c).
 - d. It prohibits surcharges for covered services. If not, this is a violation of Rule 1300.67.8 (d).
 - e. It sets forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber/enrollee shall not be liable to the provider for any sums owed by the plan. If not, this is a violation of Section 1379 (a).
2. In coordination with the Statutory Compliance work for Claims, a sample of executed provider contracts are to be selected, requested from the plan, and reviewed for compliance with the above.
3. Determine if the plan requires its contracted providers to report in writing all

surcharge and co-payments paid by subscribers and enrollees directly to such providers. [Refer to Section 1385]

4. Determine if the contract addresses books and records requirements pursuant to Section 1381 and 1385 and the related Rules.
5. Document findings in the work paper and provide any support, as appropriate.
6. Present a conclusion as to compliance for the period under review.

2. RISK BEARING ORGANIZATIONS

OBJECTIVE:

Determine compliance with Sections 1375.4 (a) and (b)(5), 1375.5, 1375.6, 1375.7 (b), 1375.8 (b), and Rule 1300.75.4.1.

PROCEDURES:

1. Obtain specimen contracts between the plan and risk-bearing organizations (“RBO”) that are on a “risk-sharing” and/or “risk-shifting” basis. [Refer to Rule 1300.75.4 (d) for definitions of these terms.] [Note: these procedures may be coordinated with Provider Contract review and claims review as deemed appropriate.]
2. Review the contracts to determine if language complies with Section 1375.4 as follows:
 - a. Requires the RBO to provide financial information to the plan and meet any other financial requirements to assist the plan in maintaining financial viability of its arrangements for the provision of services. [Also impacts compliance with Rule 1375.1]
 - b. Requires the plan to disclose information to the RBO that enables the RBO to be informed regarding the financial risk under the contract.
 - c. Requires the plan to provide payment of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.
3. Review contracts to determine that language complies with Rule 1300.75.4.1(a) (1) to (4) as follows:
 - a. Disclose on a monthly basis specific information for each enrollee assigned to the RBO; and total numbers of enrollees added or terminated under each benefit plan contract serviced by the RBO.
 - b. Disclose annually, on the contract anniversary date, the following information for

each and every type of risk arrangement (i.e., Medicare + Choice, Medi-Cal, commercial, POS, small group and individuals):

- Matrix of responsibility for medical expenses.
 - Expected/projected utilization rates and units of costs for each major expense service group with the source of the data and the actuarial methods employed.
 - All factors used to adjust payments or risk-sharing targets.
- c. For “risk-sharing” arrangements, disclose on a quarterly basis a detailed description of each and every amount that is sufficient to allow verification of the amounts allocated to the organization to the plan under each and every risk-sharing arrangement. [Refer to Rule 1300.75.4.1 (a) (5) for minimum requirements.] In addition, the plan is to include a preliminary payment report no later than 150 days and payment no later than 180 days after the close of the RBO’s contract year or contract termination date, whichever occurs first.
7. Review contracts for “risk-sharing” arrangements to determine that the plan provides the RBO annually, on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedule or other factors or units used in determining the fees for each and every service.
8. Review contracts for “risk-shifting” arrangements to determine that the plan provides the RBO annually, on the contract anniversary date, the capitation payment or amount to be paid per enrollee per month. This is to include details sufficient to allow the RBO to verify the accuracy and appropriateness of any deduction the plan may take from the capitation payment.
9. Determine whether the plan is meeting its own contractual responsibilities, as described in the risk bearing organization/provider contract. This may be done through account analysis work performed for Receivables/Payables Resulting From Risk Sharing Arrangements. If it is determined that account analysis work is not to be performed, then a sample of contracts should be selected and procedures selected from the procedures performed for Receivables/Payables Resulting From Risk Sharing Arrangements.
10. Document findings in the work paper and provide any support, as appropriate.
11. Present a conclusion as to compliance for the period under review.

3. SOLICITOR CONTRACTS

OBJECTIVES:

Determine compliance with Sections 1376 (d), 1381, 1385 and Rules 1300.59, 1300.67.12, 1300.76.2, 1300.76.4, 1300.81, 1300.85 and 1300.85.1.

PROCEDURES:

1. Obtain plan's policy and procedures for Solicitors. Review and discuss with plan as appropriate.
2. Obtain a listing of the plan's solicitors and/or solicitor firms with names of group subscribers and number of enrollees. Select a sample from this listing and review as follows:
 - a. Determine that the contract contains the required language per Rule 1300.67.12 and contains language that addresses books and record requirements pursuant to Section 1381, 1385 and Rule 1300.81, 1300.85 and 1300.85.1.
 - b. Determine if the solicitor is paid in accordance with contract terms. [Coordinate this review with examination procedures for Commissions Payable]
 - c. If the commission rate is greater than 5% of the prepaid charge on an annual basis, then request a written justification from the plan. [Refer to Rule 1300.51 (d) (BB)(3)]
3. Determine if any solicitors handle funds on behalf of the plan. If so, then determine how the plan monitors the solicitor's compliance with TNE and cash requirements of Rule 1300.76.2(a). Request and review the plan's documentation for demonstrating compliance.
4. Determine how the plan monitors the solicitor's compliance with the prohibited financial practices cited in Rule 1300.76.4.
5. Determine if an affiliate is acting as a solicitor under an Administrative Service Agreement ("ASA"). Determine that the ASA contains the required language cited in procedures 2 and 3 above. If the affiliate handles funds, then obtain and review the affiliate's financial statements for compliance with the TNE and cash requirements of Rule 1300.76.2. [See Affiliate Receivable/Payable procedures] Also, determine that the Plan is monitoring this affiliate in the same manner that it monitors other solicitor firms for compliance with 1300.76.4.
6. Document findings in the work paper and provide any support, as appropriate.
7. Present a conclusion as to compliance for the period under review.

OTHER

1. AMENDMENTS/MATERIAL MODIFICATIONS

OBJECTIVE:

Determine compliance with Section 1352; and Rules 1300.52, 1300.52.1 and 1300.52.4.

PROCEDURES:

1. At the completion of the examination, evaluate all work performed (i.e., balance sheet work and Statutory Compliance for Administrative Contracts, Management Changes, Affiliate Transactions, etc.) to determine if any operational changes occurred that require the filing of an amendment or material modification since the last DMHC examination. [Refer to Rule 1300.52.4]
2. Request copies of plan's filings with DMHC for any material operational changes noted.
3. Confirm with DMHC records that appropriate filings were previously made and/or are currently under review. If filings are not made, then require the plan to make the appropriate filing with the DMHC.
4. Review administrative arrangements/contracts with affiliates and non-affiliates, as disclosed in Statutory Compliance for Administrative Contracts and compare with administrative agreements previously/currently filed with the Department. Determine if there are material differences from filings previously approved by DMHC or if no filings made. Require the plan to make the appropriate filing with the DMHC after concurrence is obtained from DMHC chief licensing counsel.
5. The plan will be found out of compliance with the above cited Section and Rules if the plan has not made appropriate filings of amendments or material modifications.
6. Document the procedures performed and provide any support necessary to document findings in the work paper.
7. Present a conclusion as to compliance for the period under review.

2. AFFILIATE TRANSACTIONS

The Examiner's review of the balance sheet accounts for Affiliate Receivables or Affiliate Due to/Due from should be coordinated with the procedures required under Statutory Compliance to reduce any duplication of work.

OBJECTIVES:

- A. Obtain understanding of affiliate relationships as they materially impact the plan's operations and its compliance with Rule 1300.76 (e), Rule 1300.84 (c), Section, and Rule 1300.45 (q).
- B. To determine that:
 - Plan's administrative service agreements support the business arrangements that currently exist between the plan and its affiliates. [Refer to Section 1351 (d) and 1352, Rule 1300.51 (d)(F)(2)]
 - Affiliate receivables are deducted from TNE, as appropriate. [See Statutory Compliance for TNE] [Refer to Rule 1300.76 (e)]
 - Plan's financial statements are filed on a combining or combined basis with its affiliates; or on a consolidated basis with its subsidiaries. [See Statutory Compliance for Combined Reports] [Refer to Rules 1300.45 (c) and 1300.84 (c), (e) and (f)].
 - Plan's reporting of affiliate transactions in the DMHC Report Form is in accordance with GAAP. [See Affiliate Receivable procedures] [Refer to Section 1384 (c), 1345 (s), and Rule 1300.45 (q)]
 - Affiliate receivables are properly presented in the Supplemental Information that accompanies the DMHC Report Form. [See Statutory Compliance for Financial Presentation/Supplemental Information] [Refer to Rule 1300.84.06(b)]

PROCEDURES:

1. Review the plan's latest interim and audited financial statements including footnotes regarding affiliate transactions.
2. Review administrative services agreements ("ASA"), including Right of Setoff agreements, tax-sharing arrangements, guarantees, pledging of assets and identify areas that may impact plan's compliance with TNE and/or Financial Viability. Perform additional procedures as determined necessary. [See Statutory Compliance for TNE and Financial Viability; Affiliate Receivable procedures]
3. Review organization chart that presents plan and all affiliates, with reporting relationships and/or business transactions.
4. Describe all affiliate transactions in this work paper. Include the name of each affiliate, business purpose, relationship with plan, names of board members, names of key management and describe contractual arrangements between the plan and each affiliate. [See Affiliate Receivable procedures]
5. Identify entities considered affiliates in accordance with definition in Rule 1300.45 (c) and document in this work paper. [See Statutory Compliance for Combined Reporting]

6. Obtain and review affiliate financial statements, as determined appropriate.
7. Review routine, recurring affiliate journal entries, including eliminating entries for consolidation purposes, if applicable. (Plan may be requested to provide generic routine entries with no amounts stated.)
8. Review subsequent events and transactions for impact on reporting of affiliate receivables for TNE purposes and financial reporting as of the examination date. [See Statutory Compliance for Subsequent Events]
9. Document and cross-reference with Statutory Compliance for Administrative Contracts the names of affiliates transacting business with plan, relationship to plan, and general description of transactions with plan. Note differences between ASA and actual operating arrangements with affiliates.
10. Document and cross-reference with Statutory Compliance for TNE any affiliate receivables that should be deducted from TNE.
11. Document and cross-reference with Statutory Compliance for Combined Reporting for those entities identified as affiliates for purposes of combined reporting.
12. Document routine, recurring journal entries with affiliates and descriptions of the arrangements that result in those entries. Note whether right of setoff agreements support any offsetting of receivable/payables between plan and affiliates.
13. Determine if significant services are performed by an affiliate on behalf of the plan and/or if the plan is dependent upon an affiliate for funding. Consider if the examination should be expanded to include the affiliate under Section 1382 (a).

3. REVIEW OF MONITORING PROCEDURES PLAN PERFORMS OVER CAPITATED PROVIDERS

OBJECTIVES:

- A. Plans that capitate provider groups and delegate claims payment functions to these provider groups have procedures in place to ensure that these groups comply with the claims payment requirements of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1375.36, 1371.37, and 1371.8; and, Rules 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4.
- B. Plans have procedures in place to monitor the financial viability of capitated provider groups to the extent that the financial solvency of groups with material enrollment will impact the plan's ability to comply with the fiscal soundness requirements of Section 1375.1 (a)(3) and (b).

PROCEDURES:

1. Obtain from the plan a list of all capitated provider groups that provides the name of the group, address and the number of enrollees assigned, as at the examination date.
2. Obtain and review DMHC complaint and grievance reports for the plan.
 - a. Identify complaints filed that relate to payment problems and note if with a particular capitated provider group.
 - b. Obtain and review the plan's complaint and grievance log for similar concerns.
3. Obtain and review the plan's policy and procedures. Interview appropriate plan staff and gain an understanding of how the plan monitors the financial viability and claims payment practices of the capitated provider groups, and list the type of reports and other documentation it obtains from these groups in order to determine compliance with the above citations of the Act and Rules (i.e., physical on-site reviews, reports as to claim timeliness, financial statements, etc.). Document this understanding in the work papers.
4. Determine that the plan's policy and procedures specifically address compliance with the following aspects of Rule 1300.71:
 - a. Rule 1300.71 (a) (8) "Unfair payment pattern".
 - b. Rule 1300.71 (b) Claim Filing Deadline.
 - c. Rule 1300.71 (c) Acknowledgement of Claims.
 - d. Rule 1300.71 (d) Denying, Adjusting or Contesting a Claim and Reimbursement for Overpayment of Claims.
 - e. Rule 1300.71 (g) Time for reimbursement.
 - f. Rule 1300.71 (h) Time for contesting or denying claims.
 - g. Rule 1300.71 (i) Interest on the Late Payment of Claims.
 - h. Rule 1300.71 (j) Penalty for Failure to Automatically include Interest.
 - i. Rule 1300.71 (k) Late notice or frivolous requests.
 - j. Rule 1300.71 (l) Information for Contracting Providers.

- k. Rule 1300.71 (m) Modifications to the information for Contracting Providers.
 - l. Rule 1300.71 (o) Fee Schedules and Other Required Information.
 - m. Rule 1300.71 (q) Required Reports.
5. Perform procedures contained in the Technical Assistance Guide for Assessment of Health Plan Management of Claims: Delegation of Claims Payment and other related areas.
 6. Document the plan's procedures for monitoring groups that fail to meet the plan's established criteria for financial viability and/or claims payments. If the plan performs on-site audits, the plan should maintain documentation of the audit and the results.
 7. Determine if the plan requires corrective action plans to be submitted for any deficiencies and whether the plan does follow-up site visits to ensure that deficiencies are corrected. The plan should maintain copies of all correspondence and documentation for corrective action and follow-up site visits.
 8. Determine if the plan imposes sanctions on provider groups that do not come into compliance with the plan's criteria and the Act and Rules. For example, does the plan require conversion of capitated contracts to fee-for-service, de-delegation of claims processing by the group back to the plan, reporting unfair payment patterns to DMHC, more frequent submission of financial statements, and/or contract termination that includes procedures for assignment of enrollees to more viable provider groups.
 9. Determine and document the frequency of onsite visits performed by the plan and the resources dedicated to monitoring capitated provider groups to ensure compliance with the Sections and Rules cited above. This includes the levels of management and/or departments/divisions within the plan that are responsible for performing the monitoring functions.
 10. Randomly select a sample of capitated provider groups, with both small and large enrollment, from the listing obtained in procedure 1 above, from the complaint/grievance logs, and from the plan's monitoring reports.
 11. For the selected sample, request and review the plan's work paper files to determine compliance with the plan's policy and procedures and with the Sections and Rules cited above. The plan's work paper files should include, but not be limited to, the following:
 - a. Latest annual (or more current) financial statements.
 - b. Analytical review schedules.

- c. Claim payment timeliness reports.
 - d. Claim inventory reports.
 - e. Claim aging/turnaround reports.
 - f. Supporting documents for claim reserves (IBNR).
 - g. Late claim payment interest schedules.
12. Any other documentation necessary for the plan to determine that the group is in compliance with the Sections and Rules cited above.
 13. For the sample selected, obtain and review the plan's provider contract and determine that the contract sets forth the requirements for submitting financial statements [Refer to Rule 1300.67.8 (c)], subcontractor provisions, risk share arrangements, and any other provisions that may impact the plan's ability to comply with the Sections and Rules cited above.
 14. Select 2 or 3 provider groups, depending upon size of the plan, for performance of a one (1) day on-site review by the DMHC. Arrange through the plan to send a letter or email to the provider group to notify them of the date and time of the DMHC visit; and, include a request for the documents to be available during the visit. It is preferable that the documents be provided electronically and should include the following:
 - a. Claim inventory reports.
 - b. Claim aging/turnaround reports.
 - c. Claim pending reports.
 - d. Claim payment reports including payment of interest.
 - e. Sample of letters for contesting and denying claims.
 - f. Enrollment reports.
 - g. Supporting documentation for calculation of claim reserves (IBNR).
 - h. Current trial balance and general ledger.
 - i. Current bank reconciliation, bank statement and outstanding checklist.

15. During the on-site visit of the provider group, perform procedures to verify that the plan's monitoring of capitated provider groups is adequate. These procedures should include the following:
 - a. Walkthrough of claim processing operations. [See Examiner Guide for Statutory Compliance for Claims]. During walkthrough, review the provider group's inventory reports, aging/turnaround reports, supporting documentation for claim reserve schedules, late claim payment schedules. Compare these schedules or reports to what is filed with the plan. For example, compare the claims on hand at the provider group with the most recent claims inventory reports filed with the plan. Document the walkthrough. Note significant discrepancies.
 - b. Compare trial balance and general ledger to financial statements for the period submitted to the plan and for the most recent date. Note significant discrepancies.
 - c. Review the current bank reconciliation, bank statement, and outstanding checklist. Trace to general ledger, trial balance and financial statement under review. Determine if they are current and any material out-of-balance conditions exist. Note significant discrepancies.
 - d. Review supporting schedules and methodology used for calculating claim reserves (IBNR). Trace to financial statement under review. Note significant discrepancies.
 - e. Review sample denial and contest letters. Note areas of noncompliance with Sections and Rules cited above.
 - f. Compare enrollment schedules of provider group with plan's listing of enrollment by capitated group. Note significant discrepancies.
 - g. Document the names and titles of all individuals at the provider group that were interviewed.
16. Document all work performed, findings and conclusions reached in proper work paper format.
17. Document the procedures performed and provide any support necessary to document findings in the work paper.
18. Present a conclusion regarding compliance for the period under review.

4. SMALL EMPLOYER GROUP REQUIREMENTS

OBJECTIVE:

Determine compliance with Article 3.1 of the Act, beginning with Section 1357 through 1357.18.

PROCEDURES:

1. Obtain and discuss plan's policy and procedures for Small Employer Groups.
2. Obtain a listing of small group contracts in effect at the examination balance sheet date (including premium rates at examination date and subsequent renewals).
3. Select a sample of small group contracts and obtain a copy of the standard subscriber group contract and Evidence of Coverage/Disclosure Forms and review compensation areas for compliance with Section 1357 through 1357.18.
4. Obtain the plan's underwriting policy/guidelines.
5. Obtain standard employee risk rates relating to small employer group contracts at six months prior to the examination balance sheet date and at the examination balance sheet date; with related support for plan's calculations of premiums.
6. Determine that premium is calculated in accordance with Section 1357.12 and determine that proper notice of premiums was made pursuant to Section 1357.04.
7. Document the procedures performed and provide any support necessary to document findings in the work paper.
8. Present a conclusion as to compliance for the period under review.

5. OTHER LINES OF BUSINESS

OBJECTIVES:

- A. Determine if the plan is engaged in any business other than as a health care service plan.
- B. Determine if any non-Knox-Keene business was filed with the Department.

PROCEDURES:

1. Interview plan management staff and obtain an understanding of all plan's business activities.

2. Review the plan's Income Statement for any non-Knox-Keene source of the income being reported and related expenses.
3. Determine the financial risks and liabilities of this business and its impact on the plan's overall financial viability.
4. Briefly provide a written description in the work papers of the business activities of the plan, other than Knox-Keene business.
5. Determine if such business activities were appropriately filed with the Department.
6. Document the procedures performed and provide any support necessary to document findings in the work paper.
7. Present a conclusion as to compliance for the period under review.

6. ANTIFRAUD PLAN

OBJECTIVE:

Determine compliance with Section 1348.

PROCEDURES:

1. Review DMHC files for antifraud plan and any subsequent amendments.
2. Review the most current annual written report filed with the DMHC that describes the plan's efforts to deter, detect and investigate fraud and report cases of fraud to a law enforcement agency.
3. Discuss the antifraud plan with the responsible management position to determine that the Antifraud plan was implemented, is currently being used and gain an understanding of the following:
 - a. Does the Plan have designated plan staff, or contractual arrangements for persons, with specific investigative expertise to detect, manage a fraud investigation and report to appropriate government agency?
 - b. Types and frequency of the training provided to plan personnel and contractors concerning the detection of health care fraud.
 - c. Effectiveness of the procedures for managing incidents of suspected fraud
 - d. Effectiveness of the internal procedures for referring suspected fraud to the appropriate government agency.

- e. Does responsible plan personnel perform a review on an annual basis for effectiveness and make appropriate revisions that are filed with the DMHC?
 - f. Does the plan provide annual reports to the DMHC as required by Section 1348 (c)?
 - g. How and to whom is a copy of the Antifraud plan provided to and used by, within the plan and/or outside of the plan.
4. Present a conclusion regarding whether the plan is complying with its Antifraud Plan and in compliance with the annual reporting requirements of 1348 (c).

7. EMPLOYEE ASSISTANCE PROGRAMS (“EAP”)

OBJECTIVE:

Determine whether the plan’s EAP business is exempt under Rule 1300.43.14. If it is not exempt, then it must comply with the Knox-Keene Act and Regulations.

PROCEDURES:

1. Obtain and review plan’s standard EAP contracts for description of number and frequency of sessions allowed. Discuss with appropriate plan staff and obtain an understanding of the EAP line of business. Prepare a narrative to document this understanding.
2. Determine if plan has EAP arrangements with subscribers/enrollees that exceed three (3) sessions within any six-month period. If so, then the arrangements are subject to compliance with the Act and Rules. Determine that the plan has systems in place to monitor the regulated EAP business for compliance with the appropriate Act and Rules.
3. The examiner should ensure that regulated EAP business is included in any samples pulled for review of premiums, claims payment and any other appropriate areas of review. [Refer to Examiner Guide for Premium and Claims Payable/IBNR procedures and Statutory Compliance procedures for claims review.]
4. Present a conclusion regarding compliance for the period under review and cross-reference to other work papers, as appropriate.

PROCEDURES FOR PROVIDER DISPUTE RESOLUTION PROCESS (revised 11.8.05)

PDR review is to be completed prior to performance of claim review to determine if there are any systemic claim payment issues identified. [Refer to Claims Section above]

OBJECTIVES:

Determine compliance with Section 1367(h) and 1371.38; Rule 1300.71(g)(3) and 1300.71.38.

PROCEDURES:

1. Prior to start of examination, obtain most recent PDR quarterly/annual report received by the DMHC through DMHC Intranet.
2. Obtain and review the completed PDR Questionnaire, the Plan's Policy and Procedures for the PDR process, and any overview/flowcharts, template letters and/or reports. Examiner is to review each area of the completed PDR Questionnaire and provide initial sign-off, date and any written comments regarding compliance or deviations/exceptions.
3. Meet with Designated Officer and/or responsible Plan management staff (i.e., claims manager, claims supervisor, provider/network relations) to provide an overview of the Plan's PDR process. Include discussion of Plan's processing of "bundle/projects" of claims. Determine if bundled claims are considered a PDR or processed outside the PDR system (1300.71.38(a)(1)) and how they are reported.
4. Perform walk-through of PDR system/process to obtain understanding of the process and to verify that it is operating in accordance with the PDR Questionnaire completed by the Plan and with the Plan's Policy and Procedures. If separate processes are established for contracted and non-contracted providers; or, claims vs. other types of disputes, then determine if a separate walk-through is needed for each process.
5. Prepare narrative of walk-through, if determined necessary, to document the PDR system/process or to document material departures from Plan's Policy and Procedures.
6. Obtain copy of report(s) (or downloads) from the Plan that supports information filed with DMHC as of the current quarter and/or annual time period under review. Review the Plan's reconciliation of these reports to the DMHC filing. Document any departures or omissions in the report.
7. Determine Plan's definition of "dispute" or "compliant" and whether it complies with the above Rule. Determine if definitions include phone inquiries or other forms of contact with the Plan by a provider.
8. Determine if Plan's methodology for payment to non-contracting providers was filed with DMHC and if the DMHC required any changes in order to comply with the definition of reasonable and customary pursuant to Rule 1300.71(a)(3)(B).

9. Obtain PDR data for 12-month period ended as of balance sheet date in a data base and use ACL to determine and document support for the following:
 - Number of disputes received
 - Number of disputes pended
 - Number of disputes processed
 - Number of disputes resolved
 - Determine timeliness of processing PDRs
 - Sort “disputes” by category type
 - Identify category type(s) with highest number of disputes received
 - Types of resolutions
 - Number of appeals from providers of delegated capitated provider groups
 - Number of appeals from providers under plan-to-plan contract arrangements, where full-service plan is responsible under AB88 carve out for mental health parity.
10. Select a statistical sample (minimum of 50) of disputes from database using ACL. Obtain all supporting documentation for the individual dispute. For all testing of statistically valid samples (i.e. determining 95% compliance), refer to Sampling Table in the TAG (Technical Assistance Guide for Assessment of Health Plan Management of Claims) or Examiner’s Workbook. Input number of errors from the testing of the first 50 claims into formula to determine if the sample must be expanded in order to extrapolate the resulting percentage to the population. Determine that the sample includes a reasonable number of denials/upholds, overturns and non-contracted provider disputes.
11. Select an audit sample (minimum 20) based on the most frequent type of dispute, as identified in procedure 1 and 9.
12. Obtain and review documentation that the Plan maintains to demonstrate that they perform procedures to monitor that their capitated providers are in compliance with the PDR requirements.
 - Select an audit sample from the Plan’s list of capitated providers for review of separate provider file.
 - For the sample selected, review the contract between Plan and capitated provider to determine compliance with language required by Rule 1300.71(e).
 - Review Plan’s monitoring of capitated providers and ascertain whether the determination letter sent by a capitated medical group to its provider, for the denial or uphold of a dispute regarding medical necessity and/or utilization review, contains the appeal language that notifies the provider that they may appeal to the plan, as required by Rule 1300.71(e)(5).
13. Determine if the Plan contracts with other Knox-Keene Plans (i.e., full-service plan with behavioral plan for carve out of mental health services under AB88). If so, review contract to determine that it has language required under Rule 1300.71(e). Also, review Plan’s oversight procedure to see if the other Knox-Keene Plan’s determination letter sent to the

provider of an enrollee under this contract has language that notifies the provider that they may appeal to the enrollee's full-service plan of the denial or uphold of a dispute regarding medical necessity and/or utilization review, as required by Rule 1300.71(e)(5).

14. Obtain statement from the Plan regarding how it uses the PDR information to improve its administrative capacity, provider relations, and/or claim payment procedures.
15. Determine if any additional procedures should be performed based on the TAG (or Examiner's Workbook) that relate to the above Section and Rules.
16. Utilize detailed ACL Software guidelines (selection of sample), as appropriate, in performance of procedures contained in the TAG (or Examiner's Workbook) and utilize the AICPA Audit Guide for Auditing Sampling.
17. Perform ACL procedures to test for the 95% compliance requirements during the most recent three-months period (i.e., timely dispute processing and acknowledgement). Please refer to appropriate ACL procedures in TAG (or Examiner's Workbook). If the data does not allow performance of ACL testing, please refer to Sampling Table in TAG to select a sample for a three-month period.
18. Document findings in the work papers prepared and provide additional support, as appropriate.
19. Present findings for the period under review.

SECTION IV. STATUTORY COMPLIANCE FOR POINT OF SERVICE ("POS") HEALTH CARE SERVICE PLAN CONTRACTS

As part of the routine financial examination, the examiner must determine if a full-service health care service plan has filed with and received approval from the DMHC to provide a POS product in compliance with the statutory requirements set forth in Article 5.6 of the Knox-Keene Health Care Service Plan Act of 1975, beginning with Section 1374.60. This Article also provides that a specialized health care service plan that was formerly registered under the Knox-Mills Health Plan Act may offer a POS product.

The Act is amended on an annual basis, so it is incumbent on the examiner to ensure that these amendments are considered in their performance of the POS Statutory Compliance work papers and other sections, as appropriate.

This version of the Examiner Guide is updated for amendments to the Act as of February 2004.

A separate notebook, or section of a notebook, should be established as part of the examiner's work papers with the POS Statutory Compliance Index at the front. The work papers are designated with the prefix "POS-SC" and follow the POS Statutory Compliance Index that summarizes the date the

work paper was completed, the examiner's initials, exceptions noted and work paper reference number.

PREPARATION OF WORKPAPERS:

Each POS Statutory Compliance work paper is to cite the Section to which the work refers. This should be followed by the procedures performed, a narrative summary of the examiner's findings and the conclusion reached as to compliance with the specific Section.

When the Section refers to numerical quantities or required calculations, the work paper must provide the required calculation that demonstrates compliance or non-compliance.

1. TANGIBLE NET EQUITY (“TNE”) CALCULATION

OBJECTIVES:

- A. Determine compliance with the TNE requirements as calculated in accordance with Rule 1300.76 and then adjusted in accordance with 1374.64(b).
- B. Determine if monthly reporting pursuant to Rule 1300.84.3 is required.

PROCEDURES:

- 1. Obtain a copy of the plan's work paper that supports the calculation of required POS TNE as presented in the Supplemental Information accompanying the DMHC Financial Report Form.
- 2. Discuss the work paper and methodology used in the calculation with plan personnel, if necessary.
- 3. Review Section 1374.64 (b) for requirements that apply to the plan based on their net worth.
- 4. Start with the TNE calculation prepared in the Statutory Compliance for TNE pursuant to Rule 1300.76 and determine accuracy and reasonableness of the plan's calculation of required POS TNE. Use the worksheet titled Point of Service "Adjusted" Tangible Net Equity Calculation attached to the DMHC Financial Report Form, as required for the Supplemental Information pursuant to Rules 1300.84.06, 1300.84.2 and 1300.84.3.
- 5. Test the supporting schedules for all dollar amounts included in the calculation for reliability. This procedure may be performed through other procedures during the examination.
- 6. If examiner determines there is a material misstatement of the required POS TNE by the plan, then the examiner discusses proper calculation with the plan and

requests the plan to revise their calculation. The examiner is to determine if the plan needs to amend prior financial statement filings with a revised POS TNE calculation.

7. Determine if the plan maintains the minimum required POS TNE. If not, then the plan is required to file monthly reports pursuant to Rule 1300.84.3(d).
8. Determine if the plan maintains compliance with each of the following: POS working capital requirement, POS TNE requirement, financial viability, and administrative capacity. If not, then the examiner is to consider whether the plan is to be directed to discontinue the offering of the POS plan contract. [Refer to Section 1374.64 (d)]

2. ADEQUATE WORKING CAPITAL

OBJECTIVE:

Determine compliance with Sections 1374.64 (b)(1)(B) or 1374.64 (b)(2)(B).

PROCEDURES:

1. Calculate the plan's current ratio. The plan must maintain a minimum of at least 1:1 after excluding obligations of officers, directors, owners or affiliates. Short term obligations of affiliates arising in the normal course of business that are payable on the same terms, as equivalent transactions with non-affiliates are not excluded in this calculation. An obligation is considered short-term if the repayment schedule is 30 days or less. If the plan does not comply with this requirement, perform the next procedure.
2. Review the evidence provided by the plan to demonstrate that it is now meeting its obligations on a timely basis and has been doing so for the last two years.
3. Present a conclusion regarding compliance.

3. INSURANCE

OBJECTIVE:

Determine compliance with Section 1374.64 (b)(2)(D) for plans that maintain minimum net worth of at least one million five hundred thousand dollars (\$1,500,000) but less than five million dollars (\$5,000,000).

PROCEDURES:

1. Review the plan's net worth to determine if compliance with this section is required.

2. If the plan is required to maintain insurance (referred to as reinsurance or “stop-loss” insurance), then perform the following:
 - a. Obtain reinsurance policy.
 - b. Review evidence of coverage and record in the work papers the name of the reinsurance company, the amount of coverage per member and any terms, limitations or deductibles.
 - c. Review for language that obligates the insurer to continue to provide care for the period in which a premium was paid in the event the plan becomes insolvent.
3. If a plan cannot obtain insurance as required, then a plan may demonstrate other arrangements that are acceptable to the director for the cost of providing enrollees out-of-network health care services; but in this case, the expenditure for total out-of-network costs for all enrollees in all POS contracts shall not exceed 15 percent of total health care expenditures for all its enrollees. Perform the following:
 - a. Document in the work papers that the plan has not obtained reinsurance and a reason why.
 - b. Review POS out-of-network costs and compare it to the total health care costs for all enrollees for the examination period and determine compliance with 15% limitation.
 - c. Determine what alternative arrangements the Plan has arranged to meet this requirement. Review for reasonableness and determine if it has been filed and approved by the DMHC.
 - d. Present a conclusion regarding compliance.

4. DEPOSIT REQUIREMENTS

OBJECTIVE:

Determine compliance with Sections 1374.68 (a), (e), and (f) and 1377 (a).

Note: Section 1374.68 (f) states that any deposit made pursuant to this section shall be a credit against any deposit required by Section 1377(a).

PROCEDURES:

1. Calculate the required POS deposit requirement and determine compliance with Section 1374.68(a), as follows:

- a. Obtain schedule of out-of-network claims payable and IBNR claims liability for the month ended at examination date. Determine that this supporting schedule appears reasonable. [Cross reference to other work papers, as appropriate. Trace to Supplemental Information Sheet that accompanies the DMHC Financial Report From at examination period.]
 - b. Add the total of out-of-network Claims Payable and IBNR claims liability and multiply the total sum by 120%.
 - c. Compare the result in "b" above with \$200,000.
 - d. POS deposit is equal to the greater of the amount calculated in step "b" or \$200,000.
2. Obtain copies of the instruments and assignment forms from the Plan and compare with forms on file with DMHC. Verify that the bank instrument is the same investment identified on the assignment form.
 3. Determine that the proper assignment form was used and it was properly completed and executed by both the Plan and the financial institution.
 4. Determine that a deposit invested in cash or securities [Refer to Section 1377(a)], or any combination, is in an amount that at all times has a fair market value equal to the greater of the required deposit amount as calculated in procedure #1 or \$200,000.
 5. Determine that the assignment forms support the required deposit amount.
 6. Determine that any withdrawals or substitutions were properly filed with the DMHC and approved.
 7. Present a conclusion regarding compliance.

5. POS REVENUE AND EXPENSE LIMITATIONS

REVENUE LIMITATION

OBJECTIVE:

Determine compliance with Section 1374.67(a), (c) and (d).

PROCEDURES:

1. Obtain plan's work papers to support their calculation of this requirement.
2. Obtain schedule of POS Premium Revenue for the quarter ended at examination

date. Review for reasonableness or perform tests to verify. Cross-reference to/from other work papers, as appropriate.

3. Trace to Supplemental Information Sheet that accompanies the DMHC Financial Report From at examination period.
4. Perform calculation to determine the percentage of POS Premium Revenue to Total Premium Revenue for the quarter ended at examination date.
5. Determine that the percentage of POS Premium Revenue calculated in procedure #4 does not exceed 50 percent of the plan's total premium revenue at the quarter ended at examination date.
6. Present a conclusion regarding compliance.
7. If the percentage is exceeded by 2 percent, then the plan will be directed to come into compliance by the end of the next quarter. If compliance with the amount specified is not demonstrated in the plan's next quarterly report, the director may prohibit the plan from offering a POS plan contract to new groups, or may require the plan to amend one or more of its POS contracts at the time of renewal to delete some or all of the out-of-network coverage or services as may be necessary for the plan to demonstrate compliance.

EXPENSE LIMITATION

OBJECTIVE:

Determine compliance with Section 1374.67(b), (c) and (d).

PROCEDURES:

1. Obtain plan's work papers to support their calculation of this requirement.
2. Obtain schedule of POS Out-of-area Health Care Expenses for the quarter ended at examination date. Review for reasonableness or perform tests to verify. Cross-reference to/from other work papers, as appropriate.
3. Trace to Supplemental Information Sheet that accompanies the DMHC Financial Report From at examination period.
4. Perform calculation to determine the percentage of POS Out-of-area Health Care

Expenses to Total Health Care Expenses for the quarter ended at examination date.

5. Determine that the percentage of POS Out-of-area Health Care Expenses calculated in procedure #4 does not exceed 20 percent of the plan's total premium revenue at the quarter ended at examination date.
6. Present a conclusion regarding compliance.
7. If the percentage is exceeded by 2 percent, then the plan will be directed to come into compliance by the end of the next quarter. If compliance with the amount specified is not demonstrated in the plan's next quarterly report, the director may prohibit the plan from offering a POS plan contract to new groups, or may require the plan to amend one or more of its POS contracts at the time of renewal to delete some or all of the out-of-network coverage or services as may be necessary for the plan to demonstrate compliance.

6. RECORD KEEPING SYSTEMS

OBJECTIVE:

Determine compliance with Section 1374.68(b) and (c).

PROCEDURES:

1. Determine whether the plan has been tracking in-network and out-of-network POS utilization services separately.
2. Obtain a schedule of the plan's out-of-network and in-network POS utilization.
3. Present a conclusion regarding compliance.

7. RISK SHARING

This procedure may be performed simultaneously with Statutory Compliance for Provider Contract in order to limit duplication of effort.

OBJECTIVE:

Determine compliance with Section 1374.66 (e).

- Contracts between health care service plans and medical providers, for the purpose of providing medical services under POS contracts, may include risk-sharing arrangements for out-of-network services, but only if the risk sharing arrangements meet **all** of the requirements.

PROCEDURES:

1. Obtain a sample of provider contracts in which there are POS risk-sharing arrangements applicable to out-of-network services. Select different types of contracts (i.e., MG, IPA, PCP, etc.).
2. Verify that the risk-sharing arrangements within the provider contracts meet **all** of the following conditions:
 - a. Provider agrees to participate in risk-sharing arrangements applicable to out-of-network services.
 - b. Contract for providers reimbursed on a capitated or prepaid basis must provide:
 - Clear language disclosing the capitation or prepayment amount for in-network services received by enrollees under POS contracts.
 - That the arrangement does not place the provider directly at risk for or directly transfer liability for out-of-network services received by enrollees.
 - c. Contracts may provide for a bonus or incentive to reduce utilization of out-of-network services, but may not place the provider at risk for any amounts in excess of the amounts used by the plan to budget for or fund the risk-sharing pool for out-of-network service.
 - d. Clear language disclosing the following:
 - The mathematical method by which funding for the risk-sharing arrangement is established.
 - The mathematical method by which and the extent to which payments for out-of-network services are debited against the risk-sharing funds.
 - The method by which the risk-sharing arrangement is reconciled on no less than an annual basis.
3. Present a conclusion regarding compliance.

8. SUBSCRIBER CONTRACTS

OBJECTIVE:

Determine compliance with Section 1374.65.

PROCEDURES:

1. Obtain and review a sample of POS plan (subscriber) contracts to determine that these contracts:
 - a. Provide incentives, including financial incentives, for enrollees to use in-network coverage or services.
 - b. Only offer coverage or services obtained out-of-network if it also provides coverage or services on an in-network basis.
 - c. Do not consider the following to be out-of-network coverage or services:
 - Health care services received from a provider not affiliated with the health care service plan when the plan arranges for the enrollee to receive services from that provider.
 - Out-of-area emergency care provided in accordance with the procedures set by the health care service plan to be followed in securing these services.

SECTION V. POST FIELDWORK

EXAMINATION WRAP-UP

OBJECTIVES:

- A. All work papers are properly completed by staff, reviewed by EIC and reviewed by Oversight Examiner.
- B. Work papers are properly assembled.
- C. Index of Exceptions is prepared from completed work papers.

PROCEDURES:

1. BEGINNING THE TASK

- a. Generally, the EIC is responsible for wrap-up of the examination, but this responsibility may be assigned to a staff-examiner or an examiner in training to perform as an EIC. If assigned to a staff-examiner, the EIC is to ensure that the staff-examiner is aware that he/she is assigned this task.

- b. It is recommended that examiners who are not experienced at "wrapping-up" an examination use a set of completed work papers as a model.
- c. For the timetable for completing the wrap-up function, refer to the procedures for Examination Protocol - Responsibilities of the Oversight Examiner.

2. WORK PAPER COMPILATION

Compile the work papers in one or more notebooks and label by numerical "Volume" (i.e., Volume 1 of 3, etc.) as appropriate for the number of notebooks. Place an index listing contents of **all** volumes at the beginning of each separate notebook volume.

- a. The **Administration Volume** includes all the following work papers:
 - Current Examination Reports - Final Report, Preliminary Report and responses from the plan related to this examination will be filed here. [A separate notebook may be needed, if the report addresses substantial findings and requires extensive spreadsheets and documentation from the plan for corrective action.]
 - Correspondence - Notification letters (Pre-Survey and Post-Survey, if applicable). Prior Examination Final Report and any related follow-up correspondence. Various correspondence deemed necessary for performance of examination (i.e., memos or letters regarding amendment or material modification filings).
 - Trial Balance.
 - Adjusting Journal Entries.
 - Reclassification Entries.
 - Index of Exceptions.
 - Risk Assessment Memo/Planning Memo.
 - Materiality Level.
 - Analytical Review.
 - DMHC Financial Report Form for examination period and current fiscal year end.
 - Legal & Representation Letters with related index.
 - Board Minutes Review.
 - Examination Program.
 - Internal Control Questionnaire/EDP Questionnaire.
 - Management Assessment Questionnaires.
 - Time Budget and Actual Time Sheets.
- b. The **Statutory Compliance Volume**: work papers are to be organized according to the Statutory Compliance Index.

- c. The **POS Statutory Compliance Volume**: work papers are to be organized according to the POS Statutory Compliance Index.
- d. **Assets, Liabilities and Equity Volume(s)**: Assemble these work papers in one or more notebooks, as necessary, in the order of Assets, Liabilities and then Equity. The sequence of these work papers should be Lead Sheet followed by supporting work papers in alphabetical order.

3. **WORK PAPER ASSEMBLY**

The work papers should be assembled into appropriate notebook volumes, as described above. After performing this function, then the EIC should complete those work papers that are dependent upon other work papers, as follows:

- a. Trace the Examination Balance and Difference from the Comparative Sheets to the Lead Sheet.
- b. Prepare work papers for "Adjusting Journal Entries" (AJE) and "Reclassification Journal Entries" (RJE) from Lead Sheets of Assets, Liabilities and Equity work papers. Assign consecutive numbers to each AJE and RJE, beginning AJE #1 and RJE #1, throughout the work papers. Determine that all debits and credits on the AJE work paper and the RJE work paper balance.
- c. Determine that the AJE and RJE are properly input to the Trial Balance template by tracing total debits and credits columns under Examination Adjustments to the appropriate AJE and RJE work papers and trace Examination Balances back to the Lead Sheets. Next to the totals under Examination Adjustments state "Agrees to AJE and RJE W/Ps".
- d. Sub-total and total all columns of the Trial Balance, bringing the Income Statement balances to the Equity section of the balance sheet.
- e. Complete work papers that are driven from the resulting Examination Balances, such as: Statutory Compliance work papers for TNE, Financial Viability, Administrative Costs, Fidelity Bond, etc.
- f. Prepare Index of Exceptions work paper. Identify the work paper, the Section/Rule that supports the exception, a brief description of the exception and state whether the exception is to be written up in the Preliminary Report, or merely discussed at the

Exit Conference and excluded from the report. The decision to write-up or merely discuss should be determined by EIC and Oversight Examiner. In addition, identify whether the exception was also noted in a previous examination as a “repeat” exception.

g. Prepare the "Plan Overview" work paper to include the following:

- Describe the operations of the plan, to include methods of providing services (network, staff, etc.) and manner of reimbursement (capitation, fee-for service, risk-sharing, etc.).
- Describe types of products, types of subscribers (groups or individuals).
- Describe relationships with affiliates.
- Describe administrative service arrangements.
- Describe any other lines of business, any unusual arrangements in the provision of health care or the operations of the plan.
- Describe service area.
- Describe specific compliance issues as a result of this examination.

PREPARATION OF PRELIMINARY AND FINAL REPORTS

OBJECTIVE:

Determine that reports are prepared and issued in accordance with Section 1382 (c) and Rule 1300.82.

PRELIMINARY REPORT

PROCEDURES:

1. The Oversight Examiner or EIC is to discuss the examination reporting process with the executive management of a plan during the entrance conference on the first day of the examination and again at the exit conference.
2. It is imperative that all findings be discussed with plan management throughout the examination process, since all material exceptions/deficiencies and the plan's resulting corrective action will become public information in the Final Report. Continual communication with plan management will ensure that the examiner staff has a full understanding of the issues and will provide the plan with ample opportunity to present all relevant documentation.
3. The Oversight Examiner and the EIC should encourage the plan to discuss the corrective action to be taken on any significant issue prior to the drafting of the Preliminary Report and holding of the Exit Conference. In this way, the Preliminary Report can be drafted as to the specific corrective action and make the report writing process more effective for the Department and the plan.
4. Draft the Preliminary Report using the format template available to the examiner on the DMHC's shared network drive. Sample Preliminary Reports are also available for review on this network drive.
5. This Preliminary report format should be revised appropriately for Orientation Examinations and Non-Routine Examinations.
6. The Preliminary Report should be issued within 45 working days from the last day of fieldwork.
7. The narrative portions of the report should start with a citation to the applicable Act and/or Regulations; followed by the details of the deficiency found; and, then the specific corrective action requested.

8. The specific corrective action requested should be in **bold type**. If additional requests need to be highlighted differently to ensure the reader notes the distinction, then use *italic type* with or without **bold**.
9. The order of presentation of the areas within the Preliminary Report should be based on significance of the issue and determined by discussion between the Oversight Examiner and the EIC. The most significant Section should be placed first. In addition, the deficiencies presented within the Sections for Compliance Issues and Internal Control should also be in order of importance.
10. Repeat deficiencies should be highlighted as such and a request made for an explanation as to the reason the plan failed to comply with its prior corrective action or assurances that were previously provided to the Department.
11. The Oversight Examiner and the EIC will determine if a notification should be placed in the report regarding a follow-up Non-Routine examination. Such notification may be needed if significant areas of non-compliance were noted and corrective action performed by the Plan may need to be verified.
12. If a Follow-Up Non-Routine Examination is to be performed, then the EIC is to notify the examiner or analyst that maintains the Examination Aging Schedule of the need for this exam and approximate date that it should be performed. This notification should be done at the time the Preliminary Report is issued.
13. The EIC is also to report the total examination hours to the examiner that maintains the Examination Aging Schedule and to the analyst that prepares other examination reports for internal use by the DMHC. The total hours should include all actual time through issuance of Preliminary Report plus an estimate of time for review of plan response and issuance of the Final Report.
14. Issue the Preliminary Report. Oversight Examiner is to obtain USPS Priority Mail delivery date to determine date plan received the report. The Oversight Examiner is to “tickle” the plan’s response for compliance with 45 days after receipt of report. The Oversight may also send a copy of the report electronically to a contract person identified by the plan.
15. A copy of the Preliminary Report is sent electronically within the DMHC network to the analyst for placement within the DMHC electronic filing system and it is place on the DMHC shared network drive for examiners. A hardcopy copy is also placed in the Work Paper file and the Report binder. An electronic copy is also sent to a designated position in the DMHC Office of Enforcement.
16. If the plan’s response is not received within required timeframe, then a phone call should be made by Oversight Examiner or EIC to obtain reason. A reminder letter should be

issued referencing Section 1399 (c), which allows the Department to summarily suspend or revoke the license of a plan upon failure to file any report required within 15 days after notice by the Department that the report is due.

FINAL REPORT

PROCEDURES:

1. The plan's response to the Preliminary Report is received via electronic filing with the DMHC. The DMHC Filing Clerk notifies the Oversight Examiner when the filing has been accepted. The plan is also requested within the Preliminary Report to file a copy of their response directly with the Oversight Examiner via email attachment or hardcopy.
2. A hardcopy of the plan's response is placed in the Work Paper file and the Report binder.
3. The Final Report should be prepared and issued within 30 days after the plan's response has been accepted by the DMHC.
4. The Oversight Examiner may review, or request that the EIC review, the plan's response and prepare the Final Report and related cover letter.
5. The cover letter and Final Report should include the appropriate reference for the type of examination noted in the Preliminary Report [i.e., Routine Examination, Orientation Examination and Non-Routine Examination].
6. The review of the response is to determine that the plan's corrective action complies with the requirements outlined by the DMHC. The review is also to determine if the plan's response identifies any examination findings or conclusions that were presented in error by the Department. Any errors are excluded from the Final Report.
7. Draft the cover letter and Final Report using the format template available to the examiner on the DMHC's shared network drive. Sample Final Reports are also available for review on this network drive.
8. The report is drafted using the exact wording from the Preliminary Report, unless an area is determined to be in error. The plan's response as to its compliance effort is inserted through direct quote, summary or paraphrase, as appropriate. The Department's finding concerning the plan's compliance effort or remedial action is stated, as follows:
 - a. Make a statement that corrective action is acceptable and corrects the noted deficiency cited in the preliminary report. [No further action required.]

- b. If corrective action was taken on or before the time the Department receives the plan's response, then make a statement that corrective action is acceptable and that the deficiency had been corrected by the plan by the time the Department received the Plan's response. [No further action required.]
 - c. Make statement regarding that portion of the corrective action that is acceptable and then make specific requests for additional corrective action required (use **bold** type for request) for compliance.
 - d. If corrective action proposed by the plan will take longer than the 45 days from the Plan's response to the preliminary report, then make statement regarding the remedial action taken and make specific request for additional documentation that will be needed to demonstrate compliance. [Non-Routine follow-up examination may be deemed necessary pursuant to Rule 1300.82.1]
 - e. Prepare a Background page that presents the following information:
 - Date plan was licensed.
 - Organizational structure.
 - Type of plan.
 - Provider network.
 - Plan enrollment at date of examination.
 - Service area.
 - Date of last Public Routine and/or Non-routine Examination Report(s).
9. If a Follow-Up Non-Routine Examination is determined to be necessary at this stage of the report process, then the EIC is to notify the examiner or analyst that maintains the Examination Aging Schedule of the need for this exam and approximate date that it should be performed. This notification should be done at the time the Final Report is issued.
10. Issue the Final Report and the Oversight Examiner/Examiner-in-Charge monitors plan's response for compliance with the 10 days notification for appending a plan response to the Final Report. Oversight Examiner is to obtain USPS Priority Mail delivery date to determine date plan received the report. The Oversight Examiner is to "tickle" the plan's response for compliance with 10 days after receipt of report. The Oversight may also send a copy of the report electronically to a contract person identified by the plan.
11. The cover letter to the Final Report provides the plan with 10 days to review the report and then request in writing that the Department append the plan's response to the preliminary report issued pursuant to Section 1382 (c).
12. The plan may modify its response or statement and provide modified copies to the

Department for public distribution, which could include the exclusion of any information held confidential.

13. On the 11th day after receipt by the plan a copy of the Final Report is sent electronically within the DMHC network to the analyst for placement within the DMHC electronic filing system, to the Webmaster for placement on the website and it is placed on the DMHC shared network drive for examiners. A hardcopy copy is also placed in the Work Paper file and the Report binder. An electronic copy is also sent to a designated position in the DMHC Office of Enforcement, the Director and Deputy Director.
14. If any additional corrective action was requested in the Final Report, then the Oversight Examiner/Examiner-in-Charge continues to monitor for response within the remaining timeframe.
15. If the plan's response is not received within required timeframe, then a phone call should be made by Oversight Examiner or EIC to obtain reason. A reminder letter should be issued referencing Section 1399 (c), which allows the Department to summarily suspend or revoke the license of a plan upon failure to file any report required within 15 days after notice by the Department that the report is due.

PREPARATION OF INTERIM PRELIMINARY REPORT

OBJECTIVES:

- A. Immediate notification of significant violations or deficiencies found by DMHC prior to completion of examination that require immediate corrective action by the Plan for protection of the enrollee (i.e., TNE deficiency, lack of administrative capacity, failure to provide access to books and records.).
- B. Determine that report is prepared in accordance with Section 1382 (c) and is issued pursuant to Rule 1300.82.

PROCEDURES:

- 1. Draft this Interim Preliminary Report using the format template available to the examiner on the DMHC's shared network drive. Sample Interim Preliminary Reports are also available for review on this network drive.
- 2. The issuance and subsequent processing of this Interim Report should be handled the same as for the Preliminary Report; and, then a Final Report as described above in the Procedures for Preparation of Preliminary and Final Reports, but for only the issues presented in the Interim Report.
- 3. At the conclusion of the examination, a Preliminary Report will then be prepared that presents all deficiencies subsequently determined and not previously addressed in the Interim Report. The procedures, as described above, for the Preliminary Report and Final Report processes are then followed.

REPORT OF EXAMINATION HOURS

OBJECTIVE:

Maintain a record of examination hours.

PROCEDURES:

1. The EIC is to perform the following procedures at the completion of the examination:
 - a. Routine Examinations:
 - Obtain a completed Examination Time Report Form from each staff member assigned to the examination, to include the EIC and the Oversight Examiner. This Time Report is to provide the dates, hours worked each date, indicate field or office work for each day worked, work paper assignment and any training hours incurred.
 - File the Time Report for each staff member as part of the work papers.
 - b. Non-Routine Examinations, billable pursuant to Section 1382 (b) and Rule 1300.82.1:
 - Obtain a completed “Monthly Billable Time Report” form from each staff member assigned to a Non-Routine examination, to include the EIC and Oversight Examiner. In addition, obtain a copy of the Travel Expense Claims (“TEC”) for each staff member and attach it to the “Monthly Billable Time Report”. The total billable hours reported are to agree with the Examination Time Reports.
 - File a copy of the Monthly Time Report and TEC for each staff member as part of the work papers.
 - Submit originals to the Oversight Examiner at each month end through completion of the examination.
 - c. Update the Time Budget with actual hours by assignment for each staff member assigned to the examination. Determine that total hours agree with examiner time reports filed in the work papers.
2. The Oversight Examiner is to perform the following procedures for Routine or Non-routine examinations:
 - a. Review the Time Reports for each staff member and trace to Time Budget for actual hours incurred and/or to “Monthly Billable Time Report” for accuracy and completeness.

- b. Forward the total number of examination hours to the examiner or analyst that maintains the Examination Aging Schedule.
 - c. Forward the “Monthly Billable Time Report” and TEC to the analyst assigned to process billable examinations.
- 3. The Staff Examiner is to perform the following procedure:
 - a. Complete the appropriate time reports for a routine or non-routine examination for the dates, hours and work paper assignments for each assigned examination, as discussed under EIC procedures.
 - b. Provide accurate and complete time reports to the EIC at the conclusion of the examination.

EXIT CONFERENCE

OBJECTIVES:

- A. To communicate the examination findings in a final, formal manner to the plan's executive management.
- B. To provide another opportunity for the plan/Department to identify, discuss and resolve those examination findings that may be identified as an exception/deficiency in error.
- C. To discuss the correction action required for each exception/deficiency with the plan's management.

PROCEDURES

- 1. All examination findings/exceptions are to be communicated and discussed on an informal basis with appropriate plan executive management, throughout the examination fieldwork. An informal meeting for the last day of fieldwork should be held to present any findings that were not previously discussed.
- 2. The EIC is to schedule the Exit conference, as follows:
 - a. On the last day of fieldwork, discuss approximate dates of availability with plan executive management for the week prior to the estimated date for issuing the Preliminary Report.
 - b. Coordinate this date with the Oversight Examiner, who will accompany the EIC, and any other examiner staff that should attend.
 - c. Discuss with plan executive management that the Department expects the Chief Executive Officer and the Chief Financial Officer to attend the Exit Conference, and would prefer that the Chairman of the Board also be available to attend.
 - d. Confirm Exit Conference with all parties, after Preliminary Report is drafted and reviewed by Oversight Examiner.
- 3. The Oversight Examiner opens the Exit Conference with introductions, an explanation as to the purpose of the meeting, the reporting process, and then turns the meeting over to the EIC for presentation of the examination findings. Otherwise, the EIC may conduct

the entire Exit Conference and the Oversight Examiner is present in the capacity of resource and support.

4. The EIC provides a copy of the “Draft Preliminary Report/For Discussion Purpose Only” for each attendee at the meeting. Plan personnel normally is not provided with a copy of the report prior to the Exit Conference. However, arrangements may be made between the plan and the Oversight Examiner to provide the report just prior to the time of the conference.
5. Agenda for the meeting consists of the following:
 - a. Introductions: Both the Department personnel and plan personnel. Circulate a sign in sheet.
 - b. Purpose and the scope of the examination: Describe as routine or non-routine; full or limited scope.
 - c. Purpose of the Exit Conference: Disclosure of all examination findings and opportunity for Plan to present any final position in regards to these findings.
 - d. Discuss the DMHC reporting process: The Oversight Examiner or the EIC is to explain that the Preliminary Report and the plan’s response (due 45-days after receipt of the Preliminary Report) are maintained on a confidential basis by the DMHC. The Final Report is issued within approximately 30 days after receipt of the Plan’s response and is maintained on a confidential basis for 10 days before it is made public through placement on the DMHC website. The Final Report will provide the plan with the opportunity to request that a response be appended to the Final Report before it is made public.
 - e. Presentation of Findings: The EIC is to present a summary of each finding/deficiency of the Preliminary Report in his/her own words and discuss the corrective action required. Reading the report verbatim is discouraged.
 - Distribute copies of the Draft Preliminary Report to all attendees, unless provided to them prior to the conference.
 - If plan personnel have not had an opportunity to review the “draft” report prior to the conference, then provided them time to do so.
 - Provide an explanation that this report is a “draft” and that revisions may be made as a result of discussion during the Exit Conference.

- f. Discussion of Findings: The EIC should conduct the meeting in a manner that allows questions from plan personnel for each area of the report and provides for discussion between the parties.
 - g. Closing: Inform plan management of any changes that may be made to the “draft” Preliminary Report, as a result of the conference discussions. End the conference in a congenial manner, such as thanking the plan personnel for their cooperation during the examination.
- 6. The EIC is to be candid in the Exit Conference with the plan regarding the basis for any examination findings. Such findings should have been discussed throughout the examination. There should not be any deficiencies discussed at the Exit Conference that were not previously researched and discussed with plan personnel.
 - 7. Questions that arise during the conference may or may not be examination related. For those questions that cannot be answered by the DMHC staff in attendance, the EIC or Oversight Examiner should refer the plan to the appropriate DMHC source.
 - 8. If the plan has questioned any deficiencies presented, then the EIC should review any additional records/information provided by the plan following the Exit Conference. A determination should be made if this additional information will change the contents of the report.
 - 9. Although the Examination work papers are confidential, and are not normally made available to the plan, the EIC is to provide the plan all information necessary for the plan to identify and correct deficiencies. If requested, it is acceptable for the EIC to provide the plan with a copy of portions of work papers that present a list of plan records that were reviewed and found to include deficiencies.
 - 10. Prior to the close of the Exit Conference, and following all discussion, the EIC should inform plan management of any changes that may be made to the “draft” Preliminary Report, as a result of the conference. If additional research is needed by the DMHC, then arrangements should be made to do so. The Department is to communicate with the Plan as to the results of this research and impact on the report. The plan should not experience any surprises when they receive the Preliminary Report.
 - 11. The plan may ask the EIC to review a "draft" response prior to the plan filing its formal response to the Preliminary Report. The EIC or Oversight Examiner should deny the request but encourage the plan to telephone the EIC or Oversight Examiner with any questions relating to the Preliminary Report and/or the plan's response.

SECTION VI. EXAMINATIONS OTHER THAN ROUTINE

ORIENTATION EXAMINATION

An Orientation Examination is conducted approximately one year after the licensure of a plan as a health care service plan, pursuant to Section 1382 and Rule 1300.82.

OBJECTIVES:

- A. The plan is operating in compliance with its application for licensure as approved by the DMHC and/or has appropriately filed with and received approval from the DMHC for any operational changes since licensure.
- B. The plan's executive officers and key management staff have an understanding of, and means of, complying with the financial requirements of the Knox-Keene Act and Rules.
- C. The plan has adequate staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business; and, has written policies and procedures in place that provide effective controls over the conduct of the plan's business. [Refer to Section 1367 (g) and Rule 1300.67.3]
- D. The plan has an adequate accounting system in place and appropriate books and records are available to support the Plan's interim DMHC Financial Report Form.

PROCEDURES:

The Examiner should utilize appropriate areas from the Examiner Guide for Routine Financial Examinations in the preparation, performance and completion of the Orientation Examination.

1. PRE-FIELDWORK ACTIVITIES

a. The EIC should:

- Review the licensing memo, all examiner files and all DMHC filings for the period since licensure, and the most current DMHC Financial Report Form.
- Determine any significant or unique operational issues or financial concerns that should be reviewed. Determine or develop procedures to be performed and revise Orientation Examination Program, as appropriate.
- Coordinate with DMHC Licensing Counsel, health analyst and monitoring examiner to perform a joint examination.

- Discuss the proposed examination and the procedures to be performed with the Supervising Examiner and/or Chief Examiner, as appropriate.
- Notify the plan's contact person, by telephone, to discuss the objectives and to schedule the examination. Inform the plan that the examination usually takes 2 days (up to 5 days, for a large full-service plan); and, that plan executive officers and key management staff need to be available.
- Follow-up with a Notification Letter to the plan confirming the date of the examination, staffing and a list of books and records to be available for review.

2. INITIAL FIELD ACTIVITIES.

- a. Hold an "entrance" conference with executive management at the beginning of the examination to explain the Department's regulatory activities, to include a description of the various professional disciplines employed by the DMHC, and their functions. Examiners are to provide the plan with an opportunity to ask questions and should be prepared to answer related questions and/or provide referrals.
- b. Request plan personnel to provide an overview of the plan's operations, to include:
 - Organizational structure, and affiliate relationships, if any.
 - Administrative Service Arrangements with affiliates or third parties.
 - Management and other staffing.
 - Types of services provided to subscribers.
 - Contractual arrangements with subscribers (i.e., groups and/or individuals).
 - Contractual arrangements and payment mechanisms with providers (i.e., primary care, specialists, hospital).
 - Physical accommodations for administrative and medical services.
 - Systems for financial and operational records.
 - Other lines of business (i.e., exempt EAP, grants, etc.).
- c. Request a tour of the plan's administrative/medical operations and request a walk-through of the claims processing operations.
- d. Obtain and review plan's written policies and procedures, as appropriate, for areas to be reviewed during examination.
- e. Read the Board of Director Minutes for the period since licensure. Document only significant discussion and decisions of the Board. Determine impact on Plan and approved operations of the plan.

3. REVIEW OF ACCOUNTING AND FINANCIAL RECORDS

- a. No balance sheet work is performed, so the examiner cannot conclude whether the plan's interim DMHC Financial Report Form is prepared in accordance with GAAP or whether the plan is in compliance with any Section or Rule where compliance is determined through the calculation of a numerical quantity from the financial report, such as the TNE requirement of Rule 1300.76.
- b. The examiner can determine if the plan is correctly performing the calculations from the financial report (i.e., required TNE, TNE position, administrative cost percentage).
- c. Balance Sheet and Income Statement Review - Obtain an understanding of the plan's supporting records through discussion with appropriate plan personnel and perform the following procedures:
 - Prepare narratives and/or checklists for the areas of cash, premium receivable/deferred revenue, claims/IBNR, affiliated transactions, and any other unusual or significant issues relating to the plan. This might include non-Knox-Keene activities, methods of marketing, or unusual products.
 - Verify that the general ledger ("G/L") account balances, with appropriate bridging entries, agree with the line items presented on the most current DMHC Financial Report Form.
 - Review the most current bank reconciliations and verify that they tie to the G/L Cash Account. Determine that the reconciliations are current and that they do not include old "unidentified differences".
 - Review the premium receivable subsidiary and aging schedule and verify that it ties to the G/L Premium Receivable and Allowance Accounts.
 - Review the claims payable and IBNR subsidiary or supporting schedules and verify that they tie to the G/L Claims liability accounts.
 - Review supporting records for any Affiliate Receivable or Payable accounts and verify that they tie to the G/L accounts.
 - Review supporting records for any other balance sheet or income statement account deemed appropriate.
- d. Analyze the DMHC Financial Report Form to determine if it reflects the operations of the plan, as understood, and whether accounts are properly classified.
- e. Supplemental Information and Compliance Review - Obtain an understanding of the Plan's supporting records through discussion with appropriate plan personnel and perform the following procedures:

- Trace all amounts from supplemental information that accompanies the DMHC Financial Report Form to supporting data, reports, schedules and work papers of the Plan to determine if the record keeping supports the plan's financial filing and complies with related Act and Rules.
 - Determine that all calculations presented in the Supplemental Information are performed correctly, such as required amount of TNE and TNE position.
 - Determine whether plan complies with the claim requirements of Rules 1300.77.1 through 1300.77.4. Compliance with Rule 1300.77.2 needs to consider possible lack of historical claims data available to the plan.
 - Determine whether the plan complies with administrative capacity requirements of Section 1367 (g) and Rule 1300.67, as to staffing and written procedures for the financial and accounting areas. Determine if staffing understands requirements of Act and Rules and has adequately set up systems to comply.
- f. Based on the brief work performed during the orientation examination, determine whether internal controls appear reasonable. This include:
- Verifying that the plan has an accounting manual or written procedures.
 - Verifying that the procedures are in place that result in prompt reporting and analysis of variances between planned and actual performances.
- g. As a result of the limited work performed, determine whether the internal controls appear reasonable. This should include the following:
- Evaluation of the accounting system as to whether it provides necessary controls and sufficient segregation of duties.
 - Verification that the plan has an accounting manual and/or written policies and procedures for the conduct of business are in place and used.
 - Verification that procedures are in place that result in prompt reporting of monthly financial position and analysis of variances between actual and budgeted financial performance. [Refer to Rule 1300.84.3(a)]
 - Records support interim DMHC Financial Report Form as filed with the DMHC.
- h. Using the Orientation Examination Program, prepare work papers and document the procedures performed as set forth in the Examination Guide for Routine Examinations.
- i. Prepare an overview of the operations of the plan and a determination as to whether they are in compliance with operational systems filed with and approved by the DMHC.
- j. Prepare an Index of Exceptions to support findings.

- k. Perform Examination wrap-up procedures, as set forth in the Examination Guide for Routine Examinations.

4. INFORMAL EXIT CONFERENCE:

- a. The EIC will conduct an informal exit conference on the last day of fieldwork, utilizing the Index of Exceptions to communicate the deficiencies noted to plan executive management and discuss possible corrective actions.
- b. The EIC should explain the relevant financial sections of the Act and Rules pertaining to the examination and expected compliance. The EIC should encourage the plan personnel to concurrently refer to their copy of the Act and Rules. A checklist of the pertinent Sections and Rules are:
 - DMHC Financial Report Form is to be used. All financial statements must be prepared in accordance with GAAP. [Refer to Section 1345 (s)]
 - Annual audited financial statements must be certified and filed within 120 days after close of fiscal year end. [Refer to Section 1384 (c)]
 - Monthly financial statements must be filed with 30 days after close of the month end and are required for first 12 months of licensure and then if meet certain criteria. [Refer to Rule 1300.84.3]
 - Quarterly financial statements must be filed within 45 days after close of the quarter end. [Refer to Rule 1300.84.2]
 - If applicable, all financial statements are to be on a combined basis with affiliates or on a consolidated basis with a wholly owned subsidiary. [Refer to Rule 1300.84]
 - Supplemental information must be submitted, as appropriate, with each financial statement filing. [Refer to Rules 1300.84.06, 1300.84.2 and 1300.84.3]
 - Change in external auditors must be reported to the DMHC within 45 days from engagement of new auditor. [Refer to Rule 1300.84.05]
- c. Discuss regulatory examination process and resulting Preliminary and Final Reports. [Refer to Section 1382 & Rule 1300.82] Include fact that examinations are non-billable, and are required at a minimum of once every five years. Also, describe the situations where a billable examination would be performed. Rule 1300.82.1
- d. Explain TNE requirements, and how it is calculated. Include an explanation of Secured affiliate receivables, Subordinated debt, intangible assets and other adjustments that may impact this calculation. [Refer to Rule 1300.76]

- e. Explain administrative costs and its calculation as a percent of subscriber revenue. Describe those expenses that can, and cannot, be included as Administrative Costs. [Refer to Rule 1300.78]
- f. Explain Cash and cash equivalent requirements for non-contracting provider payments. [Refer to Section 1377 (a) and Rule 1300.77]
- g. Books and records:
 - Must be available for inspection during normal business hours and maintained in California unless approved by prior consent of the DMHC. [Refer to Section 1381 and Rule 1300.81]
 - Must be maintained on a current basis and be easily accessible, as well as certain records must be retained. [Refer to Section 1385 and Rules 1300.85 and 1300.85.1]
- h. Plan must have administrative capacity and effective written procedures in place. [Refer to Section 1367 (g) and Rule 1300.67.3 (a)(2), (3)]
- i. Amendments and Material Modification process. [Refer to Sections 1352 and 1352.1 and Rules 1300.52, 1300.52.1 and 1300.52.4]
- j. EIC is to provide the plan personnel with an opportunity to ask questions regarding deficiencies and/or other areas of compliance as necessary to ensure Plan's understanding of requirements.

5. POST-FIELD OFFICE ACTIVITIES.

- a. EIC is to ensure that the Orientation Examination Program is completed and provide an explanation for any procedures not performed.
- b. EIC is to review the work papers for completeness and accuracy, wrap up the work papers, prepare the draft Preliminary Report and submit to the Oversight Examiner for review, as set forth in the Examination Guidelines for Routine Examination.
- c. Schedule a formal exit conference with the Plan and issue reports, as set forth in the Examiner Guide for Routine Examination.

NON-ROUTINE EXAMINATION

A Non-routine examination is conducted on an as needed basis, pursuant to Section 1382 (b), for one or more of the reasons cited in Rule 1300.82.1.

OBJECTIVES:

- A. Determine the plan's compliance or noncompliance with the specific reason, as cited in Rule 1300.82.1 (a).
- B. Define the specific objectives based on the reason for the non-routine examination.
- C. Prepare well-defined work papers that fully support the specific area of concern that is the reason for the non-routine examination, as the results of this examination may be referred to the DMHC Office of Enforcement for appropriate administrative action.

PROCEDURES:

- 1. Verify that the justification for performing the examination is supported by Rule 1300.82.1 (a).
- 2. Determine specific objectives based on the specific area of concern that is to be reviewed and gain a complete understanding of these objectives.
- 3. Discuss the examination objectives with the Supervising and/or Senior Examiner; and, any other DMHC staff, such as the Monitoring Examiner, Enforcement Liaison, Licensing Counsel, Chief Examiner.
- 4. Perform necessary research and review of documentation maintained by the DMHC that supports the reason for the non-routine examination; and, determine the appropriate procedures needed to review the specific area of concern. Examiner should utilize appropriate areas from this Examination Guide for Routine Examinations in developing the scope of the examination and procedures to be performed
 - a. If the examination is due to concern that the plan is in compliance with Section 1376 and Rule 1300.76, then review the current DMHC Financial Report Form and supplemental information filed by the plan. Determine appropriate documentation needed and procedures to be performed in order to reach conclusion of compliance or noncompliance.

- b. If the examination is to verify representations made to the DMHC by a plan in response to certain deficiencies identified in a Preliminary or Final Report of a recent routine financial examination, then review the prior examination work papers for the specific area of concern, the applicable reports and the plan's response. Discuss with the prior EIC. Determine appropriate documentation needed to support the plan's position of corrective action taken and develop procedures to be performed in order to reach conclusion of compliance or noncompliance.
5. Prepare a Notification Letter that advises the plan that a non-routine examination is to be performed, cites the reason for the examination (that includes the provision of the Act or Rules), and sets forth that the examination is billable to the plan pursuant to Section 1382(b) and Rule 1300.82.1(b). Section 1300.82 allows the DMHC to perform examinations on an unannounced basis. Therefore, depending upon the seriousness of the reason for the non-routine examination, the Notification Letter may be hand delivered to the plan on the first day of fieldwork.
6. Perform required fieldwork and prepare appropriate work papers, as set forth in the Examination Guide for Routine Examinations.
7. Documents obtained as evidence for possible legal proceeding are not to have any markings made on them by the examiner. Make two copies, one for the work papers and one for evidence. The date and the examiners initials should be recorded on the reverse side of copies obtained for evidence. Copies of checks should include both sides, so copy the reverse side with the corner that bears the check number folded back. In this way the reverse side is identified with the check number.
8. Communication with the plan should take place throughout the examination, as set forth in the Examination Guide for Routine Examinations.
9. At conclusion of the examination, the Oversight Examiner will determine whether a Preliminary Report or Memorandum should be prepared by the EIC.
10. EIC is to wrap up the work papers, prepare the appropriate report or memorandum, and complete the required time reports and billable reporting forms using the Examiner Guide for Routine Examination

SECTION VII. OTHER

PUBLIC ENTITIES

DEFINITION:

A plan that it a public entity, for purposes of Knox-Keene regulation, is a plan that is operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that provides services or reimbursement to the **general public**. That is, it provides services or reimbursement to enrollees other than employees, retirees, and the dependents of those employees and retirees of any participating city, county, city and county, public entity, or political subdivision. Otherwise, the public entity is exempt. [Refer to Section 1349.2.]

OBJECTIVE:

Overall objectives are identical to those for all Knox-Keene licensees.

PROCEDURES:

Procedures will differ in that, although the licensee is the entire public agency, only a segment of the agency is reported to this Department.

Here are some possible differences:

1. CASH

It may be impossible to isolate cash for the plan, and therefore limit ability to perform the common "cash procedures". Cash may be buried in the entire agency's cash balance. Therefore, the examiner may need to use alternative procedures to gain comfort that the cash recorded on the plan's financial statements represents the amount that the agency's records show as assigned to the plan.

2. ACCRUALS

The plan may use a modified accrual basis of accounting or not accrue expenses and revenues at all, as the record keeping of the public agency may not lend itself to this information being provided to the plan. As accruals are almost always estimates, it is acceptable for the plan to estimate the accruals. The examiner should review the plan's method of estimating these accruals and perform procedures to determine that the accruals are reasonable (i.e., historical review of prior period of actual vs. accrued).

3. CLAIMS

Procedures should not differ from those presented within this Examiner Guide. However, the claims may consist of one large monthly invoice from a medical center that is part of the licensee (the larger agency). The examiner must understand the plan's method of providing health services and payment of providers in order to determine if alternative procedures are necessary, keeping in mind the requirements of Knox-Keene.

4. RETAINED EARNINGS

A common scenario is that the plan (the reporting entity) is subsidized by the larger entity (the licensee). This results in the plan operating at a loss throughout the fiscal year, but the annual financial statements reflect that the plan operated at "break even" (i.e., zero net income). The examiner needs to interview appropriate plan personnel and understand the funding arrangements that occurs between the plan and the public entity and determine if it is reasonable.

The subsidy (i.e., funding) may be in the form of a year-end adjustment to "claims expense", if the licensee's Medical Center is the primary provider to the plan.

If the plan operated at a profit, the profits may be up-streamed to the larger entity, which may be acceptable.

All funding arrangements between the plan and the licensee should be documented in a written agreement, such as a memorandum of understanding.

NOT-FOR-PROFIT ENTITIES

DEFINITION:

A not-for-profit plan does not have equity stock. A not-for-profit plan elects to be governed by the provisions of either the Mutual Benefit Law or the Public Benefit Law.

OBJECTIVES

- A. To determine whether assets of the plan were used for the benefit of a for-profit entity. This may be a related entity or an unrelated entity.
- B. To determine whether any plan assets held in a charitable trust were transferred to benefit any individual or groups of individuals.
- C. To document sufficient information in the work papers to enable DMHC counsel to ascertain whether the not-for-profit plan violated any charitable obligations. [Reference to Article 11 of the Knox-Keene Act, commencing with Section 1399.70 that addresses the restructuring or conversion by plans from nonprofit to for-profit status.]
- D. Overall objectives are identical to those for all Knox-Keene licensees.

PROCEDURES

Procedures performed during the examination of a not-for-profit plan do not differ from those performed during the examination of a for-profit plan. However, there are additional objectives as noted above. Information needed by DMHC counsel to determine compliance with either the Mutual Benefit or Public Benefit Laws, as result of a conversion, may be gathered while performing standard examination procedures, as follows:

- 1. Obtain and review the plan's Articles of Incorporation and Bylaws. Document the plan's charitable purpose doctrine.
- 2. Review the Board Minutes.
 - a. Identify related party transactions, significant changes in property and equipment, officers' salaries and/or bonus' that may be inappropriate or excessive, litigation and significant changes in cash.
 - b. Identify any approval of disbursements of plan assets that may appear inappropriate.
- 3. Review executed agreements. Identify the parties to the agreement, any compensation arrangements and conditions of the agreement.

4. Review cash disbursements including cancelled checks for transfer or up-streaming of funds.
5. Review investments to verify that plan assets were invested in a prudent manner. [Refer to Section 1346(a)(11)]
6. Review accounts and notes receivable to identify inappropriate transactions with affiliates, officers and directors.
7. Review property and equipment to identify inappropriate transfers or dissolution of value of property and equipment.
8. Review notes payable and long-term debt for pledging of assets and inappropriate interest rates.
9. Review operating and other expenses to determine if costs are reasonable, necessary and not excessive. [Refer to Section 1378 and Rule 1300.78]
10. Obtain and review a list of the plan's charitable donations. Include this list in the work papers, and document whether the donations appear to be within the meaning of the charitable purposes doctrine.
11. Review the most recent audited financial statements (and the notes that are an integral part of the financial statements) of all organizations to which the plan is transferring a material amount of cash, and/or other assets, for a charitable purpose. Include a copy of the financial statements in the work papers.
 - a. Document in the work papers how the cash and/or other assets are used by the recipient organization and whether this use appears to be within the meaning of the plan's charitable purposes doctrine.
 - b. In addition, perform the same procedures for the most current interim financial statements of the recipient organization if they are either dated subsequent to the most recent audited statement, or there are no audited financial statements.
12. Include in the work papers a copy of the plan's most recent Income Tax Return.
13. Determine whether the provisions of the Mutual Benefit Law or the Public Benefit Law govern the plan.
14. Document all pertinent findings. Discuss the findings with the Oversight Examiner who will coordinate with DMHC counsel as to any concerns raised by the examination findings.